

# **Brides and grandmothers: Challenges for older Filipinos in Australia**

A thesis submitted in fulfilment of the requirement for the degree of  
Doctor of Philosophy (Psychology)

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### **Declaration of Authorship**

I declare that this report does not incorporate without acknowledgement any material previously submitted for a degree in any university, or other educational institution, and that to the best of my knowledge and belief, it does not contain any material previously published or written by another person except where due reference is made.

I further declare that the ethical principles and procedures specified by the RMIT Human Research Ethics Committee's document on human research and experimentation have been adhered to in the preparation of this report.

Signed:

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29 June 2012

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## **Glossary of Terms**

ABS: Australian Bureau of Statistics

AIHW: Australian Institute of Health and Welfare

ANOVA: Analysis of Variance

ARC: Australian Research Council

Bride: An overseas born Filipino woman married to a non-Filipino Australian man

CALD: Culturally and linguistically different and diverse background

Caregiver: A primary carer of a family member who is ill/disabled/frail/grandchild

CI: Confidence Interval

CLs: Community Leaders

COPE: Brief COPE scales

DASS: Depression, Anxiety, Stress Scales

DIMIA: Department of Immigration and Internal Affairs

DSWD: Department of Social Welfare and Development

DV: Dependent Variable

FCCVI: Filipino Community Council of Victoria

Filipina: A female born in the Philippines, also referred to Pinay

Filipino: A neutral term for people born in the Philippines, also refers to a male born in the

FWV/FW: Overseas-born Filipino women living in the State of Victoria

Grandmother: An overseas-born older Filipino woman who migrated close to or after

Intermarriage: Marriage outside own ethnic background

Intramarriage: Marriage within the same ethnic background

IV: Independent Variable

M: Means

MANOVA: Multivariate Analysis of Variance



Mental health: Refers to emotional states of anxiety, depression and stress in this study

Mixed marriage: Marriages between people from different birthplace groups

NGOs: Non-Government Organisations Philippines

Pilipino: Refers to the official language of the Philippines

PLS: Plain Language Statement retirement to care for grandchildren in Australia

Researcher: Refers to the PhD candidate conducting this study.

RMIT HREC: RMIT Human Research Ethics Committee

SD: Standard Deviation

Spouse: An overseas-born Filipino woman married to a Filipino man in Australia

Urban: Comprises capital city; Non-urban refers to the remainder

## **Abstract**

Migration of women from Eastern or less developed countries such as the Philippines to economically booming Western countries such as Australia for marriage or family reunion is a phenomenon that continues into the 21<sup>st</sup> century. The migration of three groups of Filipino women (intermarried brides, intramarried spouses, and grandmothers) from the Philippines from the 1980s has contributed to the gender imbalance in the Filipino migrant community in Australia. Many intermarried Filipino brides settled in regional and remote areas of Australia, did not have children, and were primary caregivers of much older husbands, while grandmothers migrated in old age to look after their grandchildren in Australia to enable adult parents to participate in the workforce. Most spouses and brides achieved university education and left their professional jobs in the Philippines to join their husbands in Australia.

Given settlement adjustments and the challenges that are inherent with migration to another country (Bennett, 2006; Chou, 2007; Thomas, 2003), and the buffering effects of social support on the health of migrant women (Jirojwong & Manderson, 2002) particularly for the elderly without children (Wu & Hart, 2002), it is expected that changes in family structures, roles, and living arrangements would impact on both the future care needs and mental health of migrant Filipino brides (B), spouses (S) and grandmothers (G) in Australia. However, little empirical research has been conducted to examine these opportunities and challenges in detail, and to investigate the impact on mental health. The limited existing literature on the Filipinos in Australia has mainly focused on the intermarriage relationships.

Thus, utilising Wong's (1993) resource-congruence model of adaptation, this study explored the psychosocial challenges confronting older Filipino women who migrated to Australia between 1960 and 2006 as young brides (B) or spouses (S) or as elderly

grandmothers (G). This study investigated the relationship between migration variables, coping strategies, acculturation, social support, and mental health of female Filipino migrants in Australia. The women, aged between 40 to 89 years, were recruited from metropolitan and rural regions across five Australian states (Victoria, South Australia, New South Wales, Queensland, and Tasmania).

Using cross-sectional design, a combination of qualitative and quantitative approaches to data collection was utilized in the study. The research was undertaken across two stages. First, Stage 1 comprised focus groups with both community leaders (CLs) and a group of Filipino women (FW) in Victoria to identify the stress, coping, psychosocial resources, acculturation, perceptions of kinship and family, cultural values and beliefs, and service utilisation of female Filipino migrants in Victoria. Second, using the themes identified from Stage 1, Stage 2 further explored the acculturation experiences, caregiving roles, psychological resources, social resources, coping strategies, mental health, and use of community health services by the Filipino women migrants in both urban and regional areas across Australia. In addition, follow-up interviews with eight intermarried Filipino women were conducted to examine the nature of their intercultural marriages in more detail.

The results of Stage 1 indicated that the CLs perceived that the needs of the older Filipino migrants in Victoria were not dissimilar to the needs expressed by the Filipino women themselves. The needs of this migrant group were in fact found to be consistent with those reported in many culturally and linguistically diverse (CALD) communities in Australia (Hugo & Thomas, 2002; Thomas 2003, 2004). The primary concerns reported by participants in the study concerned: 1) health; 2) access to services; and 3) isolation and homesickness, while secondary concerns related to 1) migration and settlement, 2) aged care, and 3) family related issues. Participants reported filial responsibility, family centredness, gratitude, love, respect, religiosity, and inner strength are primary personal resources that enable caregivers

to meet the challenges of their roles. Family-connectedness was also shown to be paramount in providing care particularly for grandchildren and spouses. Further, participants only accessed community services after exhausting family resources.

The themes identified in Stage 1 formed the basis of the framework for Stage 2 of the current study. The results of various statistical analyses of the data collected from the national survey conducted in Stage 2 showed significant group differences in demographic profiles, acculturation level, coping strategies, perceived social support, and mental health. Brides married to non-Filipino Australian men reported the highest levels of acculturation, while the elderly grandmothers reported the lowest levels of acculturation, indicating brides had a more Australian disposition than Filipino spouses and grandmothers who were married to Filipino men. In regards to coping, there were significant differences across the three groups, with emotional support having the strongest significant effect followed by more positive or active coping strategies such as positive reframing, religion, instrumental support, active-coping and planning. There were also significant differences in levels of depression, anxiety, and stress across the three groups. In regards to social support, the results showed significant differences between grandmothers and the other two groups on both social support from other people and total support, and between grandmothers and spouses on support from family and friends. The results from the regression analyses also showed that social support was a strong predictor of anxiety and stress, but only for grandmothers. The results of the qualitative data collected from follow-up interviews of eight Filipino women married to non-Filipino Australian men also reflected the themes of higher acculturation, coping strategies that included avoidant styles, accessing social support outside the family and yet maintaining traditional Filipino values such as family centredness, filial responsibility, religion and marital values reported by the women in both Stage 1 and Stage 2.

The results from both the women themselves and the Community Leaders suggest support for Wong's (1993) resource-congruence model of adaptation that strongly posits that stress occurs in a cultural context and that successful adaptation starts with the development of various types of resources, particularly, personal resources. The results highlighted the influence of traditional Filipino values on a Filipino's appraisal of challenges and adaptation to changes in roles and environment and the usefulness of indigenous Filipino psychology. The findings of this study also appear to suggest a model that shows that levels of psychological health can, in part, be explained by resources – personal (age, education, physical health, coping styles, acculturation strategies, education, marital situation) and social environment (family, community, culture, religion, and social support). Future research with this cultural group could include overseas born Filipino men who used assisted skilled migration in 1970s and more recently to fill labour shortages in Australia. Future research could also examine the wellbeing of the grandchildren looked after by their grandmothers during 1970 to 1980s and could explore intergenerational differences between grandparents, parents, and their children.

## **Chapter 1: Overview of the current study**

The most recent report on Australia's health by Australian Institute of Health and Welfare (AIHW, 2012) has shown that most Australians feel positive about their quality of life. However, the report has also highlighted the fact that social and economic disadvantages such as low levels of income and education, unemployment, limited access to services, and inadequate housing directly correlate with risk factors such as reduced life expectancy, disease incidence and prevalence, and physical/biological and behavioural risks (AIHW, 2008, 2012). Specifically, for migrant women in Australia distance to healthcare services, lack of transport, lack of services and information available in languages other than English, and lack of culturally sensitive and linguistically appropriate services and information pose as barriers to accessing healthcare services and information and be active participants in their own care. Thus, to provide a respectful and responsive service, it is essential for health professionals to be cognizant of the social, cultural, linguistic, spiritual and gender diversity of service users including carers (Katsikitis, 2011).

Australians born in Asia are a diverse group reflecting huge economic, cultural, and social diversity. One of these Asian groups are the Filipinos who are uniquely different in history, religion and migration experience to other Asian groups. These variations impact on their cultural values, perspectives, and acculturation in the Australian society compared to other Asian Australians. The Filipinos may also have mental health experiences that may be different to other cultural groups (Sanchez & Gaw, 2007). Therefore in understanding the overseas-born Filipino migrants in Australia, particularly intermarried women and elderly mothers, it is imperative to consider the socio-cultural background of the host country, Australia, as well as the country of origin, the Philippines. Such a background is needed to understand the fundamental elements that influence Filipino individuality, interpersonal relations, and resources particularly as they age in the host country.

The fabric of Filipino migration to Australia has been formed by gender and marital status when 30 years ago, large groups of Filipino women migrated to Australia as brides to non-Filipino Australian men or as grandmothers to assist families. Media reports on “mail-order brides” particularly in the 1980s to early 1990s depicted negative stereotyping of Filipino women (Cahill, 1990; Chuah, Chuah, Reid-Smith, Rice, & Rowley, 1987; Cooke, 1986; Cunneen & Stubbs, 1997; Iredale, Castles, Innes, & Millbank, 1992; Woelz-Stirling, Kelaheer, & Manderson, 1998). Subsequent studies on intercultural marriages reported difficulties with settlement for this group of migrant women (Jackson & Flores, 1989; Kelaheer, Williams, & Manderson, 1999; Woelz-Stirling, Manderson, Kelaheer, & Gordon, 2000; Kelaheer, Potts, & Manderson, 2001). Other studies found that among Filipino women, mental illness was highly stigmatised (Thompson, Manderson, Woelz-Stirling, Cahill, & Kelaheer, 2002), and that for intermarried Filipino women, the stigma attached to being stereotyped “mail-order bride” influenced their reluctance to seek support and access appropriate community services (Kelaheer, Potts et al., 2001). On the other hand, a study by Kelaheer, Williams, and Manderson (2001a) found that Filipino women in intermarriages appeared to experience less stress in adapting to Australia and fewer problems with health and accessing health services, suggesting that intercultural relationships may also facilitate acculturation. They also found that women’s expectations of infrastructure, population distribution, and lifestyle were influenced by the women’s social status and where they originated from in the Philippines. Unfortunately, few major scientific studies have been undertaken in Australia to explore the migration circumstances and settlement experiences of the female Filipino migrant community and the impact of their experiences on their mental health as indicated by levels of anxiety, depression and stress as indicators as they approach old age.

Roces (2000) has argued that globalisation has a major impact on the gendering of migration, in particular, labour migration, economy, tourism, and the bridal diaspora. In regards to Filipino migration to Australia, from 1970s to 1980s a significant number of women migrated as fiancées or intercultural “brides” to non-Filipino Australian men or spouses to migrant Filipino men in Australia. Many intermarried brides settled in rural areas of Australia and experienced negative stereotyping on arrival (Cahill, 1990). Another substantial group of Filipino women migrants to Australia since 1970s were grandmothers who migrated in old age to look after their grandchildren in Australia so that the parents could participate in the workforce (D’Mello & Esmaguél, 1990). This female migration particularly in 1980s further impacted on the gender ratio in the Filipino community in Australia.

Following Wong’s (1993) resource-congruence model of adaptation, this study aimed to explore the psychosocial challenges confronting older Filipino women who migrated to Australia between 1960 and 2006 as young brides or spouses and elderly grandmothers. The study investigated the migration circumstances, changes in roles, coping strategies, social support, and mental health of female Filipino migrants across Australia.

### **Aims of the Research**

This study investigated the relationship between migration, coping, acculturation, social support, and mental health of female Filipino migrants in Australia. The women migrated to Australia under different circumstances – as intercultural brides or intramarried spouses or elderly grandmothers. The women, aged between 40 to 89 years, were recruited from metropolitan and rural regions across five Australian states (Victoria, South Australia, New South Wales, Queensland, and Tasmania).

The research was undertaken across two stages. First, Stage 1 comprised focus groups with community leaders and a group of Filipino women in Victoria to identify the



stress, coping, psychosocial resources, acculturation, perceptions of kinship and family, cultural values and beliefs and service utilisation of female Filipino migrants in Victoria. Second, using the themes identified from Stage 1, Stage 2 further explored the migration circumstances), acculturation experiences, caregiving roles, psychological resources (e.g. marital status, education, spirituality/religion), social resources (e.g. income, living arrangements, rural/urban, family ties, social network), coping strategies, mental health (anxiety, depression, stress), and use of community health services by female Filipino migrants in both urban and regional areas across Australia. Follow-up interviews of eight intermarried Filipino women were also conducted to further explore their intercultural marriages. Ultimately, it was anticipated that the findings would contribute to the development of a model of positive ageing and community aged services for this migrant community in Australia.

### **Research Questions**

#### **Stage 1**

1. To explore the issues identified by both community leaders and Victorian female Filipino migrants during their settlement and in adjusting to their role as caregivers.

#### **Stage 2**

1. To explore the level of acculturation, coping strategies, and mental health (anxiety, depression, stress) of three groups of female Filipino migrant women (namely Brides, Spouses, Grandmothers) living in both urban and regional areas in Australia.
2. To examine the relationship between demographic variables (age, marital status, education level, migration circumstances, years in Australia, children in Australia, location of residence, caregiver role), acculturation level, social

support, coping strategies, and mental health (anxiety, depression, stress) of Filipino women in Australia.

3. To examine the nature of intercultural marriage according to the narratives of eight Filipino brides.

### **Significance of the Study**

This project was funded by the Australian Research Council (ARC) with the Filipino Community Council Victoria Inc. (FCCVI) (the umbrella body for Philippine organisations in Victoria) as the industry partner. It was envisioned that the research would provide valuable information on the association between the caregiving experience (as grandparent, spouse or adult child), psychological health, and service utilisation of female migrants. The results would also contribute to the framework of a culturally sensitive model of health care for older migrants particularly older Filipino women in Australia. The results of this project informed the proposed model of positive ageing for this predominately female community who are dispersed in both rural and urban areas. By including a sample of participants living in isolated mining and regional towns, the project added important data on social and environmental determinants of health and wellbeing among cultural groups in rural and urban areas. The project is valuable in the promotion of mental health of older migrant women who have come to Australia under special circumstances, which still apply to other groups of migrant women today.

### **Theoretical Background Underpinning the Study**

Wong's (1993) resource-congruence model of successful adaptation to stressors, in particular the Asian elderly (Wong & Ujimoto, 1998), is the primary model of stress used in this study. Using this model of coping, the current study investigated the relationship between migration circumstances, acculturation experiences, social roles (caregiver, non-caregiver), coping strategies, mental health and use of services by female Filipinos who migrated to

Australia under different circumstances (Brides, Spouses, Grandmothers). Participants were grouped according to reasons for migration: Group B for Brides intramarried to non-Filipino men, Group S for Spouses intermarried to Filipino men, and Group G for Grandmothers who migrated in old age to look after grandchildren in Australia.

### **Overview of the Chapters**

Chapter 1 highlights the aims and questions and significance of the study. Chapter 2 examines migration from a psychological perspective, including demographic change, population ageing, service utilisation, and women in Australia. Chapter 3 examines the history of Filipino migration to Australia, with particular emphasis on Filipino women as brides and grandmothers as they confront ageing and caregiving roles in Australia. This is followed by a more extensive discussion on the fundamental elements of the Filipino culture and values that influence these women as migrants. Also reviewed is the literature on Filipino migration to Australia and the Filipino “mail-order bride” phenomenon in Canada, the USA, Japan and Australia, which highlights the challenges women face as migrants in large western countries and globalised economies. Chapter 4 provides the theoretical background, research aims and questions, while Chapter 5 describes the methodology for the two stages of the research. Chapter 6 presents the rationale, method, procedure, and results for Stage 1 of the research study. Stage 1 comprises focus groups with community leaders and Filipino women in Victoria. These focus groups elicited themes that led to the development of the interview questions for the next stage of the study. Chapter 7 presents the rationale, method, procedure and results of Stage 2 which comprised of a national survey of Filipino women across five states in Australia. Chapter 8 provides a discussion, methodological issues and limitations of the study, theoretical and practical implications, and conclusion.

## **Chapter 2: Australia's Population and Health**

Chapter 2 will give a picture of the Australian demographic change, population ageing, migration and mixed marriages, health, primary caregiving, and health service utilisation in Australia.

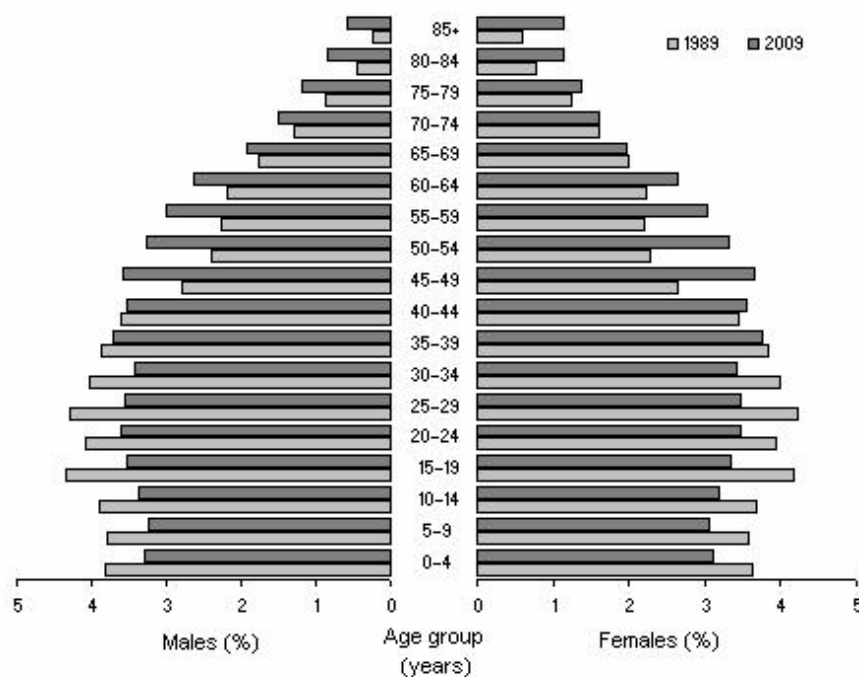
### **Population Demographic Change in Australia**

Australia has faced various challenges as a result of its British colonial past, resurgence of Aboriginal identity, and waves of massive immigration from European and Asian countries, and more recently from the Indian continent, African and Middle Eastern countries. The global phenomenon of the feminisation of migration from developing countries to western countries had also influenced Australia's demographic profile with the immigration of women as "brides" for intercultural marriages with long-term Australian residents like the European immigrants, and more recently with Australian residents. All have impacted on Australia's cultural diversity, demographic features, and urban and rural environments. Thus, it is not uncommon to expect that the institution of family has been influenced by Australia's cultural diversity (Beck-Gernsheim, 2007).

### **Population Ageing**

Like most developed countries, Australia faces significant intergenerational challenges, given that its population is ageing as a result of sustained fertility and increased life expectancy. Australia's ageing population is expected to increase between 30.9 million and 42.5 million people in 2056. This means that compared to one in eight in 2007, one in four Australians will be aged 65 years and over in about 50 years. As more Australians live longer and healthier lives, this group poses significant challenges to governments, policymakers, service providers, and the community (Gibson & Grew, 2002; Gray & Kendig, 2002; McCallum & Mundy, 2002; Thomas, 2007). The increase in the number of older people poses challenges for housing arrangements, income support, and health and social care

services (AIHW, 2002). More alarmingly, the proportion of elderly in rural and remote areas is expected to age at a greater rate than urban areas, posing even more considerable challenges as AIHW (2012) highlighted that people who live further from the major cities are less likely to be healthy compared with those living in the major cities of Australia. As shown in Figure 1, the number of Australians aged under 15 years has decreased while the number of Australians aged 65 years and over has increased between 1989 and 2009.



*Figure 1.* Population structure, age and sex – Australia 1989-2009.  
Source: ABS (2009).

Another feature of the ageing population is the changing cultural diversity. Australia is a multicultural society enriched by migrants from over 200 countries (Hugo & Thomas, 2002) as a result of changes in immigration policies after World War II (AIHW, 2002; Thomas & Balnaves, 1993). The data from recent census indicates 26.8% of the Australian population were born overseas (AIHW, 2012). Earlier settlers after WWII were primarily from European countries. Data shown in Tables 1 and 2 indicates that in 2001, countries in Asia like China, India, and the Philippines were among the largest source countries of migrants to the USA, Canada and Australia.

Table 1

*The Five Largest Foreign-born Groups in Australia, Canada and the USA*

Australia 2001			Canada 2001			United States 2001		
Country	Number	Percentage	Country	Number	Percentage	Country	Number	Percentage
Total	4,105,688	100.0	Total	5,647,125	100.0	Total	31,107,889	100.0
UK	1,033,647	25.2	UK	614,610	10.9	Mexico	9,177,487	29.5
NZ	355,765	8.7	China*	345,520	6.1	Philippines	1,369,070	4.4
Italy	218,718	5.3	India	322,215	5.7	India	1,022,552	3.3
Vietnam	154,830	3.8	Italy	318,095	5.6	China*	988,857	3.2
China*	142,781	3.5	US	258,420	4.6	Vietnam	988,174	3.2
Greece	116,430	2.8	Hongkong	240,045	4.3	Cuba	872,716	2.8
Germany	108,220	2.6	Philippines	239,160	4.2	Korea	864,125	2.8
Philippines	103,942	2.5	Poland	181,810	3.2	Canada	820,771	2.6
India	95,455	2.3	Germany	177,675	3.1	El Salvador	817,336	2.6
Netherlands	83,325	2.0	Portugal	155,770	2.8	Germany	706,704	2.3
All others	1,692,575	41.2	All others	2,793,805	49.5	All others	13,480,097	43.3

\*excluding Hong Kong and Taiwan.

Source: MPI Data Hub, 2010.

Table 2

*Birthplaces of Persons Aged 65 and Over from CALD Backgrounds Ranked in Order of Size, Australia 1996–2026*

Birthplace	1996	2006	2011	2016	2021	2026
Italy	1	1	1	1	1	1
Poland	2	6	11	13	14	16
Germany	3	3	3	3	3	5
Greece	4	2	2	2	2	2
Netherlands	5	4	4	4	4	7
China	6	5	5	5	6	4
India	7	10	9	8	9	8
Vietnam	13	11	10	6	5	3
Philippines	21	19	15	11	7	6
Lebanon	17	14	12	12	10	9

Source: Gibson et al., 2001, p. 82.

In 2001 people from European countries such as Italy, Greece, Germany, the Netherlands and Poland who settled in Australia after WWII represented a significant number of people from culturally and linguistically different or diverse (CALD) backgrounds (AIHW, 2002). By 2026 the ranking according to population size of older persons aged 65

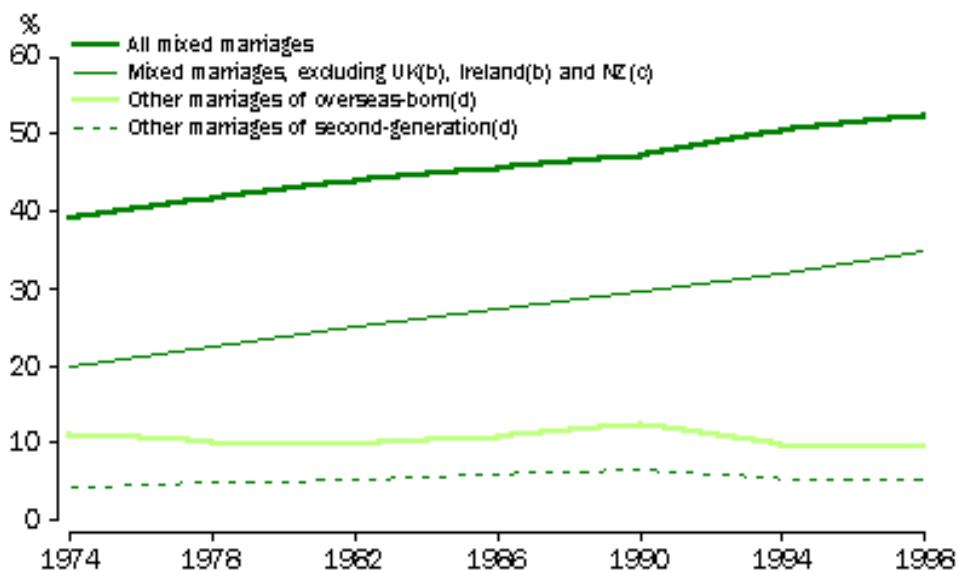
and over from CALD backgrounds in Australia will be Italy, Greece and Germany, and the Netherlands will still be in the top ten, but will slowly be replaced by migrants from Asian countries such as Vietnam, China, and the Philippines (Gibson, Braun, Benham, & Mason, 2001). The Philippines will jump from the fifteenth in 2011 to sixth largest group from CALD backgrounds age 65 years and over in 2026.

### **Migration and Mixed Marriages**

Literature has indicated that even where migration provides better opportunities for both male and female migrants to have better lives, escape social and political cruelty, and support remaining relatives in the country of origin, they can also be exposed to new challenges or vulnerabilities. This may be as a result of various conditions such as precarious residency status, and abusive working or domestic conditions, which may increase their exposure to health risks including mental health. Sponsorship for extended family members appears to be particularly important for migrants, especially those from Middle Eastern and Asian countries (Storer, 1985). The literature indicated that family reunion program may have implications, particularly on the wellbeing of CALD migrants (Storer, 1985; Watson 1973). As cited in Watson (1973), several studies have indicated that the best adjustment is achieved when adaptations occur within a solid primary group, preferably, when the family adapts as a unit to the new country. Many migrants believe that their grandparents, brothers and sisters were important components back in the country of origin and are particularly needed as support during their settlement in a new country. If this is the case, it can be argued that for certain groups of women, such as young Filipino brides and older grandmothers who migrated to western countries on their own, they were potentially exposed to precarious situations in the host country.

Migration for marriage featured prominently in Australian history. McDonald (1995) claimed that the extensive intermarriage between Northern and Western Europe (English,

Irish, Scottish, Welsh, German, Dutch & Scandinavian) in the past 200 years explains the Englishness of the Australian culture and of family values because of the intermarriage between these earlier groups of settlers. Recent groups of migrants from various continents (Asia, Middle East & India) have had a strong influence on its cultural diversity, values and aspirations. Not unlike the literature in the US (Nadal, 2011), researchers and service providers in Australia need to be more aware that Asian-Australians come from different historical and cultural views. There are groups like the Filipino–Australians, who are uniquely different from other Asian groups like the Chinese, Vietnamese, Japanese, Thailand or Indonesians, in history, religion and migration experience. The Filipino-Australians might also have mental health experiences different to other Asian groups. Thus, caution should be exercised in making generalisations about Asian populations.

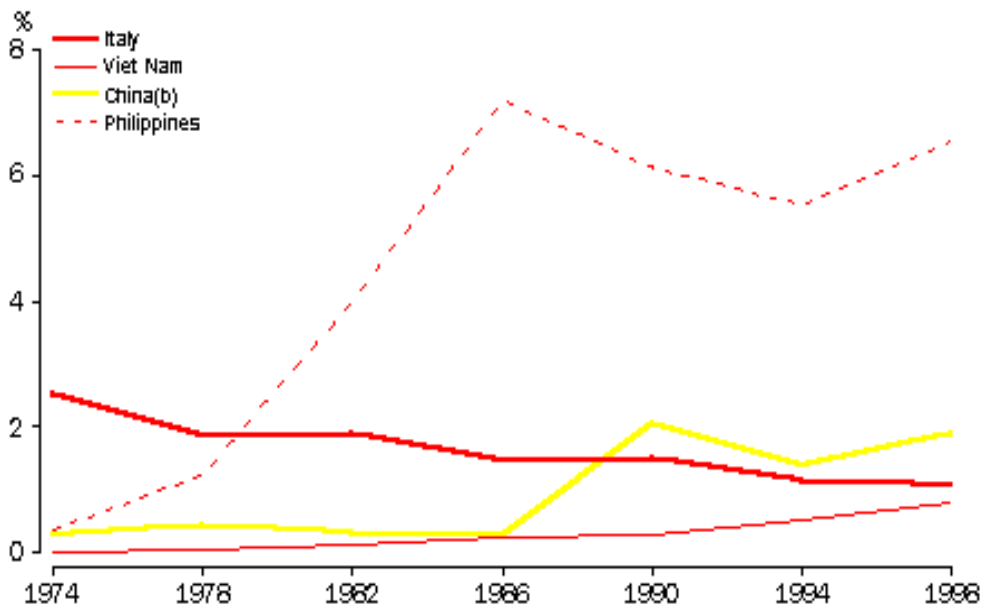


*Figure 2. Mixed marriages in Australia 1974-1998*  
 Unpublished data. Marriage Registrations, 1974–1998 (selected years only).  
 Source: (ABS, 2006).

The 2006 census highlighted the influence of intermarriage immigration. It showed that 59% of all couples were both members born in Australia, while for the remaining 41%, one or both members of the couple were born overseas. The UK was the most common birthplace of 41% of men and 38% of women with Australian-born partners. Equally at 11%,



both men and women's partners were with people from New Zealand. Italy was the third most common source of men partnered with Australian-born women. On the other hand, Australian-born men were more likely to find a partner from Asian countries like the Philippines (ABS, 2006). Literature showed the large proportion of Philippines-born brides marrying long-time Australians compared to other recent overseas-born brides. Nearly 32% of Filipino brides marry long-term Australians in contrast to only 9% of grooms born in the Philippines marrying long-term Australians (ABS, 2006).



*Figure 3. Overseas-born brides in Australia 1974 -1998*  
Unpublished data. Marriage Registrations, 1974–1998 (selected years only).  
Source:(ABS, 2006).

Thus, intermarriage migration is a major factor in the gender imbalance in the Filipino migrant group in Australia. This unique feature of the Filipino migrant community in Australia highlighted the need to understand the various factors that influence their health and service utilisation in the host country.

### **Health in Australia**

A recent report by the Australian Institute of Health and Welfare (AIHW, 2011a) on key indicators for chronic disease and associated determinants showed that the prevalence of

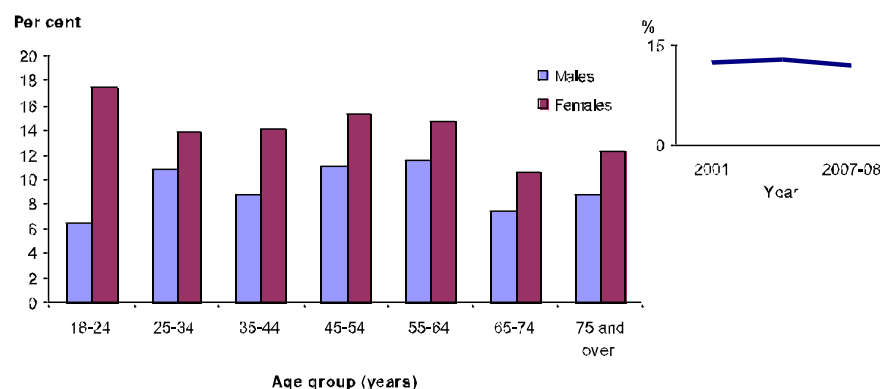
chronic disease increased over time. The determining factors include the ageing of the population, improved treatments and lifestyle factors. Other determinants of health include social and environmental factors, and the individual's physical and psychological make-up. According to the June 2011 report of AIHW, Type 2 Diabetes was ranked first, psychological distress second and depression third, as high-impact in nature.

### **Mental health in Australia.**

The rate of population ageing poses a challenge to mental health professionals in assessment, diagnosis and treatment. The Australian Social Trends (ABS, 2009a, 2011) show that one in five Australians aged 16–85 years have a mental disorder and that women are more likely than men to have a mental illness (22% and 18% respectively). Recent data indicate that the three main mental health related problems patients presented at general practitioners practice were depression, anxiety and sleep disturbance, accounting for 60% of all mental health related problems (AIHW, 2012).

### ***Anxiety and stress.***

The later AIHW report defines psychological distress as a non-specific term to include sadness, frustration, anxiety and negative mood states from mild to moderate, transient or persistent (AIHW, 2010, 2011a; Fragar et al., 2010). For the purpose of the current study, anxiety and stress are used to refer to these mood states. Figure 4 shows that the proportions of adults with high or very high levels of anxiety and stress are very different according to age groups and gender. Larger proportions of females report higher levels for each age group.



**Figure 4.** Age-specific and age-standardised prevalence of high/very high psychological distress in adults, 2007–2008 and 2001 to 2007–2008 (Source: AIHW, 2011a).

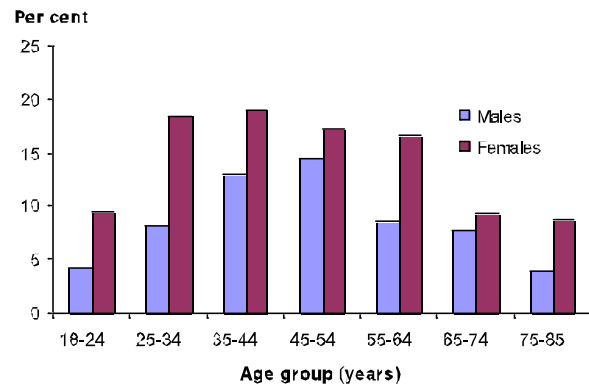
For both men and women, those living in the most disadvantaged areas reported higher levels of stress than those living in less disadvantaged areas. More women living in major cities reported high levels of stress, while it is the reverse for men which may be attributed to the gender differences in the ways men and women typically cope with stress. Women tend to report more stress and symptoms of depression and anxiety than men (Kelly, Tyrka, Price & Carpenter, 2008), while the unemployed in rural areas reported the highest levels of stress and functional impairment (Fragar et al., 2010). A more recent report shows there is not a marked variation in mental health between those living in major cities and those living in outer regional, remote and very remote areas of Australia, or those living in areas of least disadvantage and most disadvantage (AIHW, 2011b, 2012).

### ***Depression.***

Depression is a major health problem in Australia, with an estimated 12.6% of adults in 2007 reported to have had depressive symptoms at least once in their life (AIHW, 2010, 2011a, 2012). Across all ages, more females reported experiencing depression during their lifetime compared to males. Females aged 25–34 years and 35–44 years reported the highest

rates of lifetime depression, while men aged 45–54 years reported the highest prevalence of depression for males. These figures may be explained by gender differences in the use of coping strategies (Kelly et al., 2008).

Several studies have shown that women tend to use coping strategies to change their emotional responses to manage stressors that are more associated with anxiety and depression, while men tend to use more problem-focused or instrumental strategies. Women who tend to use emotion-focused coping styles reported higher levels of anxiety symptoms. Women with negative cognitive approaches to stress tended to have more anxiety and depressive symptoms. Men using problem-focused or instrumental strategies to cope with stress, complemented by positive cognitive styles, usually report lower depressive and anxiety symptoms. However, it can be hypothesised that men aged 45–54 years may be confronting particular life transition-associated stressors that may have contributed to higher risk of experiencing depressive symptoms, but still less than levels reported by women (Kelly, et al., 2008). In addition, middle-aged men who experienced gender role conflict, and maintained traditional masculine values (e.g. projecting strength) and life goals (e.g. career success), were associated with significantly higher levels of distress, depression and anxiety (Heath & Thomas, 2006). The literature review on depression in older adults by Fiske, Wetherell, & Gatz (2009) supported such findings. Depression has also been associated with behavioural and lifestyle risk factors for coronary heart disease (Reddy, Dunbar, Morgan, & O'Neil, 2008). Marital status has shown to be another predictor of psychological health, with married older individuals reporting less depression than those who are not married (Thomas, 1999).



*Note:* The estimate for males aged 75-85 years has a relative standard error of 25% to 50% and should be used with caution.

*Source:* AIHW analysis of the 2007 SMHWB.

**Figure 5.** Adults who experienced depression during their life by age group (Source: AIHW, 2011a).

The variations in mental health might be slightly different for migrants. Previous research showed that older migrants who originated from urban areas experienced better mental health than those who came from rural areas. This variation suggests that adjusting from rural to urban life is an additional stressor to migration (Thomas, 1999). There is some evidence that support provided by the same or a like community is associated with positive mental health outcomes (Beiser, Barwick, & Berry, 1988). Literature indicated that the mental health of certain CALD groups such as the Filipino migrants is understudied. Iwamasa and Hilliard (1999) proposed examination of how elderly migrants conceptualise mental illness particularly primary prevalent disorders such as anxiety and depression. They also recommended determining how depression and anxiety are experienced and expressed by this group, and to identify the risk and protective factors so that they can be incorporated into effective and culturally appropriate programs for both prevention and intervention. Further, they posit that traditional Asians' cultural values such as respect for the elderly and cooperation should also be included in the programs.

### **Primary caregiving.**

The Australian census in 2006 showed that older people were also more likely than younger people to assume primary responsibility for caring for a person with a disability, long-term illness or problems associated with old age. For people aged 25–44 years, 10% provided unpaid primary care to a person with disability, long-term illness or problems related to old age. For the middle-aged 45–64 years, 16% were most likely to have provided unpaid primary care for frail parents and relatives, or a partner who had developed health problems and needed assistance. Younger caregivers aged 15–44 years usually cared for a parent or child, while carers aged 45–64 years old cared for a child or partner, and those aged 65 and over cared for a partner. Caregivers aged 15–44 and 45–64 were co-resident carers at 23% and 24%, respectively. In the 50s and 60s age group, people became grandparents and tended to look after children not their own.

Hugo and Thomas (2002) state that the wellbeing of the elderly depends on intergenerational exchange between them and the working age population. According to McGoldrick (2003), it is not the number of activities but the lack of support and the inability to choose one's roles and organise one's resources to meet the demands that place a burden on women's wellbeing. Contrary to the earlier finding that intergenerational exchange is not influenced by the comparative size of the network (Kendig, 1986), later studies found that the following influence exchange: the size of two generations and their cohort characteristics, perceptions, culture and attitudes, family status, cohesions and structure (Millward, 1998), economic ties, living arrangements and length of residency in the new country (Glick & Van Hook, 2002; Hugo & Thomas, 2002) and historical forces (Becker, Beyene & Canalita, 2000). The exchange through caregiving can lead to growth, meaning and integration of values, roles and strengths with a new identity (Jones, Zhang, Jaceldo-Siegl, & Meleis, 2002), enhanced family relationships and greater sense of purpose in life (Burke, Reddy & Cantwell-

Bartl, 2004). It is crucial that the relationships between members of the different generations are understood as social support has a huge effect on the wellbeing (Moos & Moos, 1987) and adjustment of the older migrant (Thomas & Balnaves, 1993). Kendig (1986) argues that intergenerational support is structured by both gender and marital status, suggesting that women who do not have children are expected to care for their aged parent.

Recent Australian census data indicate that in general while the extended family rarely lives in the same household, the extended family networks are very active in providing financial support for housing or other services that family members need. The extended family is also active in providing child care, which is usually provided by grandparents while parents are at work. Contrary to common belief, there are more grandparents providing child care in the outer areas of the cities than those in the inner and middle parts of the cities (ABS, 2011).

Women generally assume the caregiving role at a younger age than men and are reported to be more likely to care for people other than their own partners, while men primarily provide care to their partners. Although there are some adult men who are the primary caregivers (Carers Victoria, 2004), most men share or support their wife's caring role rather than take primary responsibility (Watson & Mears, 1996). A study by Wells (1999) about gender differences in anticipated willingness to care for a spouse and expected caregiver burden showed that men reported more willingness to care than women, and expected less caregiving burden. These differences may be attributed to motivational factors or men may have a less realistic view of what caregiving entails. Wells also found that women who were more religious were more willing to provide spousal care. Other studies indicated that younger caregivers reported better health than older caregivers, females tended to report better health than male caregivers (AIHW, 2002), and that caregivers are at an increased risk of depression and anxiety (Gallicchio, Siddiqi, Langenberg, & Baumgarten,

2002; Parks & Novielli, 2000). However, literature has shown that rural caregivers have access to fewer formal supports but do not report greater burden, poorer health status, or fewer health-engaging behaviour than urban caregivers (Bedard, Koivuranta, & Stuckey, 2004).

For some families, it is also not uncommon that the grandparents co-reside with their adult children and grandchildren (Lauterbach & Klein, 2004), which could be short term (Kendig, 1986). Glick and Van Hook (2002) predicted that ethnic groups, where the recent migration of older adults is more prevalent, would have higher rates of parent–child co-residence. A study on eldercare in a Filipino community in America (Kimura & Browne, 2009) showed the importance of cultural values, and expectations that a spouse and adult children should care for their aged parents, but that the perceptions of these values and expectations appeared to be changing due to economic challenges associated with migrant status. Economic barriers influenced a shifting in positive attitudes toward formal service use. Economic challenges prevented adult children living in America to provide care to their aged parents. Given these factors, contrary to expectations, the results suggested that the participants were more open to formalised government assistance. There is paucity of available research on older Filipino population that lend support to shifting of cultural values and expectations regarding care for the aged parents in Australia. However, limited literature indicated a possible increase in use of formal aged care services by ethno-specific agencies (Butler, 2002; D’Mello & Esmaquel, 1990; Hugo & Thomas, 2002; Kelaher, Manderson, & Potts, 2003; San Jose, 1995). The specific factors that may have influenced this slight shift are yet to be clearly determined.

The costs and benefits of multiple roles on the wellbeing of women have attracted the attention of researchers and policymakers (ABS, 2011; AIHW, 2002; Carers Victoria, 2004; Hugo & Thomas, 2002; Wells, 2005). Literature has shown that chronic diseases impact not



just on those who suffer from them but also on their carers, the wider community and the general population. Literature also showed that the highest proportion of individuals accessing general medical practitioners were older adults, while the opposite is true for accessing psychological services (Wells, 2005). It is predicted that demand for psychological services by the older population will increase partly due to the increase in the aged population over the next 20 years. Therefore, to plan for provision of more responsive and inclusive services for a multicultural Australian society, it is important to have a better understanding of the psychological health of not just baby boomer cohorts but also generation X women, who have been juggling multiple roles as daughter, wife, mother, careerist/worker, and as a primary caregiver.

Some literature suggested that contrary to popular myth, some women who occupied multiple roles reported higher life satisfaction and lower depressive symptoms (Barnett, 2004). It would be interesting to note how this suggestion would apply to migrant women like the Filipino groups in this report. Further, it would be interesting to determine the health status differentials across rural/regional and metropolitan Australia and how these differences influence the health and help-seeking behaviours of the Filipino migrants across Australia.

### **Health and Service Utilisation in Australia**

Epidemiological studies concur that lifestyle risk factors, physical environment factors, and access and utilisation of health services influence health. Wells (2005) has also shown that older adults tend to access general medical practitioners, while the opposite is true for accessing psychological services. Social health researchers have identified additional factors such as socio-economic status, race and ethnicity, gender, socio-cultural and psychological factors that determine health status and health-promoting behaviours.

Dixon and Welch (2000) showed that the health status of rural Australia was substantially inferior to metropolitan counterparts. They advocated for research using place as

a risk factor instead of rural personality or its proxy to socio-economic status (SES).

Literature has also shown that stigma and lack of knowledge about services serve as barriers to mental health services for adults, while previous knowledge of or relationship with a specific service/provider and financial subsidies serves as enablers for adults with high-prevalence psychological disorders (Reddy, Morrison, & Schlicht, 2009).

Studies on migrant health indicated that despite a high incidence of emotional distress (Easteal, 1996; Kelaher et al., 1999; McCallum, 1994) and mental health problems (Thomas, 1992; 1999) migrants continued to access community and health services less frequently than their Australian-born counterparts (Thomas, 1998; Thomas & Balnaves, 1993; McDonald, 1994; Xenos, 2000) and American counterparts (Sue, 2002) and tended to report physical symptoms rather than mental health issues (Pablo & Braun, 1997; Thomas, 2003, 2004). This under-utilisation of health services by ethnic communities has been associated with several factors: lack of information about the healthcare system, the cost of the service, lack of access to mainstream services, geographical distribution, transport problems, and cultural and linguistic appropriateness of services (Henderson & Kendall, 2011; Jones et al., 2002; Pablo & Braun, 1997; Sozomenou, Mitchell, Fitzgerald, Malak, & Silove, 1999; Sue, 2002; Thomas, 1993, 2004; Xenos, 2000; Yu, Huang, & Singh, 2004). On the other hand, a longitudinal study by Chou (2007) found that although the Asian migrants received more formal and informal support in Australia, older migrants reported higher levels of distress than those who came from western countries. This result may be attributed to previous findings that linguistic factors contributed to the social isolation for older migrants (Thomas, 2003), and that marital status change (widowhood and divorce) may lead to depression in old age (Bennett, 2006).

For Filipino migrant women, a longitudinal study of the mental health of Filipino women after giving birth in Australia revealed that migrant women had smaller social

networks and reported more symptoms of anxiety and depression five years after giving birth, but did not differ from Australian counterparts 14 years after giving birth (Alati, Najman, & Williams, 2004). The reduction in symptomatology suggested the positive adaptation of Filipino women in the long term. In addition, Thompson et al. (2002) identified three important cultural transitions for Filipino women: first, from collectivist society in the Philippines to an individualistic society in Australia; second, obstacles to practise central aspects of a Filipino culture at home through food preparation and language use; and third, unexpected language difficulties, particularly for those in intercultural marriages. Other factors that influence consulting mental health services were that the term “mental” was highly stigmatised and more associated with being “crazy”, which would bring shame to the family. Emotional problems were perceived by Filipino women as temporary, and even if they wanted to access mental health services, these services were deemed expensive and linguistically inappropriate. Several studies (Heras, 2007; Kelahe et al., 2003; Kelahe, Williams, & Manderson, 2001b) proposed that better information about health services be provided to address these barriers to health care.

In summary, a review of available literature on migration, health and ageing highlighted the pivotal roles of women in the country of origin and country of destination. Migrant women’s motivation for migration varies but they bring with them personal resources to adapt to different challenging situations not just to meet their needs and protect their health, but also to cater for the wellbeing of others. It has been well documented that migrant women face challenges and are more at risk of ill health because of structural elements (e.g. visa category or status, recognition of overseas qualification, employment opportunities), as well as the circumstances of their migration and the culture and attitudes of their host society. As women continue to migrate for work or family reunification to care for grandchildren, or spousal migration (intra- and intercultural marriage), influenced by “pull

and push” factors and globalisation, just like decades ago, gendered migration for marriage from less developed (e.g. Philippines, Thailand) or newly re-established societies (e.g. Russia, Baltic countries) to western countries like Australia continues. Migration of older women to join members of their migrant family in the host country also continues. Given that poor self-rated health predicts higher incidence of mental health problems in older migrants, particularly those from Asian countries, it is vital that empirical studies on disparate groups of Filipino migrants also continue. Scientific studies will help identify their specific needs and the particular risks they face in the host country so that more equitable and culturally and linguistically responsive services can be provided to them.

### **Chapter 3: Filipino Migration, Culture and Values**

The waves of migration of Filipino women have had a huge impact on the gender ratio and geographical dispersion of this ageing community in both regional and isolated areas of Australia (ABS, 2006). Given their unique circumstances as migrant spouses/caregivers (ABS, 2006; Cahill, 1990; D'Mello & Esmaguel & 1990; San Jose, 1995), these groups of Filipino women differ from other members of the general community yet there is paucity of empirical research on this group. The lack of data suggests a need to further understand this group. Therefore, it is important to examine the psycho-social resources available to Filipino brides and grandmothers that promote health and wellbeing as they encounter various challenges of caregiving and ageing in Australia.

With the ageing of the Filipino migrant community in Australia, the community faces the challenge of providing policy, programs and services to meet their changing needs, values, behaviours and attitudes. Most research on Filipino women has focused on their marriages and less on the society they live in and their adaptation to different situations (Cabigon, 1995; Cahill, 1990; Chuah, et al., 1987; Cuneen & Stubbs 1997; Easteal, 1996; Woelz-Stirling et al., 1998). More recent studies started to include health status of the Filipino women (Kelahe, Potts et al., 2001; Kelahe, Williams et al., 2001b). It is important that factors that disproportionately affect these women, such as domestic violence, multiple roles, and lower socio-economic status, be considered to understand how women cope with health conditions and maintain mental health (AIHW, 2012; Kelahe, Potts et al., 2001; Kelahe, Williams et al., 2001a, 2001b; Thomas, 1992, 1989).

Culture influences the experience and manifestations of mental health and the social and cultural context of risk. Heras (2007) strongly emphasised that family matters, gender roles, intergenerational conflict, acculturation strategies, and ethnic identity should be considered when working with Filipino women. Thus, this section will highlight important

factors related to the Filipinos in general, followed by discussion about Filipino migrant “brides” and grandmothers in Australia. It will highlight the salient socio-cultural and psychological constructs and values specifically relevant to overseas-born migrants with emphasis on Filipino women who migrated to a western country like Australia for intercultural marriage. The discussion starts from a brief geographical and historical view of the Philippines, followed by the Filipino family (kinship and structure, nuclear and extended), courtship and marriage, the Filipino woman, the Filipino elderly, Filipino values, and challenges with ageing in the Philippines. This is followed by a detailed discussion on the gendered migration of Filipinos with particular emphasis on the Filipino “mail-order bride” phenomenon in Canada, the USA, Japan and Australia.

### **The Philippines**

Like Australia, the Philippines is a unique and diverse country. Unlike Australia, it is an archipelago that consists of 7,107 islands. Seventy per cent of the archipelago is on two large islands, Luzon and Mindanao. Geographically, the Philippines are divided into three main regions: Luzon, Visayas and Mindanao. The Philippines has been under colonial rule of Spain, America and Japan. There are more than 111 linguistic, cultural and racial groups in the country. The inhabitants of the Philippines are called Filipinos and they are members of different ethno-linguistic groups: 13 large lowland groups and hundreds of upland and remote coastal groups. These varied groups speak languages that are not mutually understandable. In general, however, the language structure belongs to what Filipino scholars call Austronesian or Malayo-Polynesian. The official national language is called Filipino (based on Tagalog). The Philippines is the only predominantly Catholic country in South East Asia. In 1998 the total population of the country was 73,130,885. The elderly population, that is, persons 60 years and over, was estimated to be 4,280,364 or 5.8% of the total population. The total population of the country in 2004 was 86,241,697. It was estimated that people aged 65 years

and over represented 4% of the total population, with a ratio of 77 males for every 100 females.

### **The Filipino Family**

Unlike some western societies like Australia, where emphasis has been on the rights of the individual, the emphasis in the Philippine society is on the family as a group unit. Literature indicates that scholars from diverse disciplines still consider the family as the basic institution of society (De Guzman, 1999; Jocano, 2002; Medina, 2001).

#### **Filipino kinship and family structure.**

Jocano (2002) maintains that there are three important sources of social relationships in Filipino society: kinship, *pamilya* (family) and *barkada* or *samahan* (peers). Traditionally, kinship regulates and directs Filipino relationships and behaviour. Kinship represents the overall framework of Filipino society and within this domain is the family. The family demands interest and loyalty more than any other institution in the wider society. It encompasses social, political, economic and religious aspects of a Filipino's life. Although Medina's (2001) studies centred on Filipino families, her extensive review highlighted community life in the Philippines as organised around the family and kinship structure, roles and functions, marriage patterns, the elderly, and social changes.

Despite variations in focus in literature on regional and ethnic differences or methodological approaches in studying basic Filipino precepts and practices, a review of literature showed that scholars consistently posit that in order to understand the Filipino family, it is important to analyse its basic social structure. This includes roles, status, values, norms, beliefs and behaviour patterns, and how they are arranged, organised and interrelated (Jocano, 2002; Medina, 2001; Natividad, 2000; Soriano, 1995). The composition of the family, relationship of its members, system of descent, residence, and authority are some of the characteristics that describe the structural arrangements of a family.

Traditional definitions of family do not include other family forms such as couples without children, single parents, live-ins/de factos, homosexuals, and remarried or step families. Even in the Philippines, the 1995 census showed an emergence of these forms that belong to non-traditional families (Medina, 2001). New definitions recognised the plurality of family forms but also included those whose members do not live together.

Families are classified as either nuclear or extended. The nuclear family typically consists of a married man and woman with their children, while the extended family may include a number of nuclear families linked together by kinship bonds between parents and siblings and recognised shared responsibilities and emotional relations (Castillo, 1979). The typical Filipino family is monogamous as dictated by law and by Christian religion. The members of a Filipino family are linked together by certain bonds and reciprocally supporting behaviour (Medina, 2001). Husband–wife relations are linked by the conjugal bond, social pressure to preserve marriage, and economic cooperation. Parent–child relations are characterised by very strong filial bonds between parents and children. Parents consider it their moral obligation to work hard to give education, discipline, love, care, and protection to their children. In return, children love, respect, and obey their parents. Children are also expected to perform their work role based on their age and sex. Daughters are expected to care for the home; sons are trained in farm work or business to prepare them to take over the responsibilities when required. Sibling relations are also characterised by mutual love, protection, and respect. Brothers are expected to look after their sister; older siblings are responsible for the care of the young when parents are sick or away. This help may require an older sibling to stop schooling or postpone marriage to help support or educate the younger siblings (King & Domingo, 1986). Younger siblings are therefore expected to obey and respect their elders. This sibling relationship continues even after everyone is married.



The extended Filipino family includes families of orientation and procreation from both the husband's and wife's side (Castillo, 1979; Jocano, 2002; Medina, 2001). Like the Filipino nuclear family, the extended form is characterised by a strong sense of solidarity, mutual financial and emotional aid, pooling of resources, and sharing of responsibilities. The extended family household may include a widowed grandmother, unmarried aunt, or cousin or nephew. Contrary to expectations, there are more nuclear households in rural areas than in urban, and household size increases with increasing urbanisation (Castillo, 1979). The increase is influenced by the presence of other relatives who want to work or study in the city and non-relatives of the household like domestic help.

Not surprisingly, Arce (1994) found that nuclear families at the start of the family life cycle are usually headed by men and demonstrate a high child dependency ratio; nuclear extended families at the end of the life cycle are usually headed by women, mostly widows, with high adult (elderly members and other adult relatives) dependency ratios. Interestingly, Medina (2001) noted that only a small percentage of Filipino families reach "empty-nest" stage of the life cycle where the couples are by themselves, or where a widow/widower lives alone. Older people in the Philippines turn to their extended family for companionship and support in their old age. Thus, the older the member, the greater the tendency for them to belong to an extended family household. This practice is a reflection of the filial care and support Filipinos give to ageing relatives, particularly parents and grandparents. Traditionally, the Filipino family is consanguineal so even relationships with distant cousins, aunts, and uncles are recognised. An individual is usually judged by the kind of blood relative they have.

The Filipino descent system is typically bilateral or bilineal as Filipinos trace their ancestry through both paternal and maternal lines (Natividad, 2000). Close interaction and mutual help and support are expected of all relatives from both sides. However, the Filipino

naming system is paternal. The Filipino family is identified by the surname of husband's father's kin. The mother's surname is retained as the middle name. Recently, however, some women have spelt out their maiden name or, in the case of intermarried women, the maiden name is retained without adopting the foreign husband's surname.

There is no fixed pattern of residence among Filipinos. Elderly parents, however, prefer to live with unmarried children because they feel they are imposing if they live with children who have families. Natividad (2000) noted that although co-residence is still common and higher in urban areas, it also elicits some tensions. Further, she cited interesting data from an unpublished Philippine Elderly Survey in 1996 which showed that there seemed to have been a shift in the attitude of the Filipino elderly in the Philippines about homes for the aged. Twenty-six per cent of the respondents said they would consider homes for the aged if they were available in their area.

The Filipino family is generally classified as equalitarian, that is, authority is divided more or less equally between husband and wife. Formally, the authority in the traditional Filipino family is vested in the husband, but it is widely recognised and accepted that managerial power and influence almost always remains with the wife. The wife traditionally manages the budget, governs the household, defines and allocates the roles of children in the household. Authority in the Filipino family usually points vertically down on the basis of age. The older children, regardless of gender, are dominant over the younger ones. But this dominant authority comes with expectations and obligations. Generations also function as a guide to social etiquette, interpersonal behaviour and emotional ties. Members of older generations expect and usually demand respect from the younger generations. However, Jocano (2002) reported that the relationship between grandparents is usually one of intimacy, respect, and friendship. Another concept that is related to generation is seniority or age-grading. Within the kin group and the family, status conferred is based on descent, affinity

and religious rituals. Should individuals deviate from the existing kinship rules, they risk being sanctioned by the other members of their group by being ostracised, or the subject of gossip or scandal.

In a Filipino family, an individual is always at the middle of a complex network of kinship ties where the family interests are always the primary concern over those of the individual. Duties and obligations are focused on responsibility to parents, siblings, grandparents and children. Loyalties and cooperation extend beyond the family to immediate, intermediate and distant relatives. Loyalty to kin may include emotional, financial and legal support. The kin provides further assistance in times of need in areas where the family is not able to do so. This kinship network is manifested by Filipino migrants in Canada and the USA through social, psychological and economic support given to relatives in both the Philippines and other countries (Medina & Natividad, 1985).

### **Changing structures and functions.**

As the Philippines rapidly changes from a traditionally agricultural to modern industrial society, structural and functional changes are also taking place within the family and kin group. Medina (2001) argued that new behaviour adapted to modern conditions changed the interaction network and patterns of relationships in both nuclear and extended families. The improvement of transportation, mass media, the internet and the communication system has introduced new values, norms and attitudes that impact on traditional age-sex status, role expectations, and other patterns affecting the family structure. The increasing independence of the individual shows an increasing tendency to break away from the family by living separately. Medina found that large sibling size and low household income push adult children in rural areas to leave the parental home and search for better opportunities in the city.

The pattern of authority is also changing. Although deference may still be given to the elderly and the young, the better-educated breadwinner may become the decision-maker and acting manager of the household. Husbands no longer monopolise the breadwinner role as in many households both husband and wife are income earners. Thus, traditional authority and power of the male head diminishes with migration. On the other hand, the wife assumes the double role of housewife-worker as a result of economic necessity, personal growth and interest or circumstance.

Medina (2001) found that female-headed households are concentrated in urban areas and more developed regions of the country due to migration within the country and overseas. This migration has provided the migrant with non-kinsmen to establish social relations and economic ties. However, mutual help and protection, both materially and psychologically, are still expected and provided particularly during crisis.

Other studies (Asis, Huang, & Yeoh, 2004; Butler, 2002; Wilks, 2005; D'Mello & Esmaguel, 1990; Jocano, 2002) supported Medina's position that the traditional values and familial orientation of Filipinos persist in spite of rapid social change in the society. Jocano (2002) added that continuity of traditional ways are being sustained because rapid changes are taking place mainly in urban areas while rural villages remain traditional. However, new urban ways are temporarily adopted as rural families move to urban centres for new opportunities. He strongly argued that as new ways rapidly change (e.g. fashions and trends) before new patterns of behaviour, attitudes, values and sentiments stabilise, the old rural patterns are retrieved and used to handle the pressure of adaptation to the changing environment. Thus, this retrieval contributes to the maintenance of traditional institutions, values and sentiments. What remains to be investigated is whether this pattern of adaptation to change also true for Filipino migrant women in Australia.

### **Courtship and marriage and the “email-order bride”.**

Traditionally, kinsmen are heavily involved in courtship and choice of partner in the Filipino families. This is still more prevalent in rural areas, and less in cities. Parents, siblings, other relatives, or peer groups (*barkada*) directly or indirectly influence the selection of the partner. Young Filipinos strive for more independence in their choice of a life partner. There has been an increase in civil weddings or “live-in” relationships that is not widely accepted as an alternative to marriage. Filipinos generally prefer to be endogamous, that is, requiring choice of the same religion, race, nationality, or class (Medina, 2001). Mass media has played a significant role in modern matchmaking. The “mail-order bride” phenomenon particularly in the 1980s drew widespread negative attention to Filipino women as many migrated to Australia, Germany, Belgium, Italy, Switzerland and the USA. In response to the plight of many intermarried Filipino women being abused by their foreign husbands, the Philippine Congress enacted a law in 1990 banning “mail-order bride” services. With advanced electronic technology, however, courtship and matching have taken place in cyberspace for intramarriage and intermarriage in particular.

Filipino women are generally motivated to improve their financial capacity, escape poverty in the Philippines, and fulfill their obligations to their family and kinship (Cahill, 1990; Cooke, 1986; Kelaher, Williams et al., 2001b; Medina, 2001). Medina (2001) asserted that the “mail-order bride” or “email-order bride” phenomenon may be considered a symptom of prevailing socio-economic conditions in the Philippine society. She further argued that the predisposition of women to marry foreigners and move out of the Philippines is more tied to an ailing economy, rather than to follow the “marriage norms.” These norms may be a desire to marry someone with at least the same or better social background, or idealising anything foreign (referred to as a “colonial mentality”), and/or having an optimistic view of life in another country.

## The Filipino Woman

A Filipino woman is referred to as “*Filipina*” or “*Pinay*”, the feminine equivalent of the neutral formal Filipino and colloquial “*Pinoy*”. Filipinas have confronted many challenges forced by certain events such as post-war politics, western industrialisation, globalisation and modernisation of societies. These challenges have compelled Filipino women to explore different strategies, though sometimes contradictory, to adapt to their environment (e.g. local/international; regional/metropolitan; rural/urban; patrilocal/matrilocal), develop, utilise and conserve their resources, and fulfill their usually multiple roles (e.g. worker, wife, mother, daughter, sister, relative, household, more recently as politician) and obligations to family and kin first, and self second if not last. Roces (2000) argued that generally the proactive response to social and economic change by Filipino women, whether they are politicians or wives of politicians or overseas contract workers, was still in the context of family and kinship and more akin to the notion “modernising” than “feminism.” Since the 1970s Filipino women have emerged as more active agents in the Philippine society in various areas such economic and politics, and as Imelda Marcos exemplified, have been powerful in kinship politics. Previously, the images of “women power” reflected beauty and religiosity. However, particular historic times in the Philippines have changed that image. In addition, there have been a number of Philippine legislations to improve the status of Filipino women.

As commonly regarded by Philippine society, a man has official and public power bestowed on him as the “head of the family” or household, while the woman has the unofficial power as the wife, mother, manager of the household and economist controlling the family purse. Around the same time Imelda Marcos was increasingly wielding her unofficial power and charm, many Filipino women were increasing their participation as active agents in economic and work spheres by migrating, both within the country and internationally, as

overseas contract workers or spouses to non-Filipinos. Since the 1970s the Philippines has actively joined global migration and has been regarded as a major source of contract workers and “brides” in Asia and worldwide. This outmigration was fuelled by slow economic growth, political instability, and overpopulation while there were increasing demands for skilled workers in booming economies in the Middle East, Europe, Canada, the USA, Australia, and certain parts of Asia like Japan.

As highlighted in the previous discussion about authority in the Filipino family, officially, the authority in the traditional Filipino family is vested in the husband. However, it is widely acknowledged and accepted in the Philippines that real power and influence remain with the wife. Traditionally, the woman manages the budget, governs the household, defines and allocates the roles of children in the household. It would be interesting to note if Filipino women in intermarriage relationships outside the Philippines, were able to replicate the same arrangements, and if they did, to what extent and benefit to them and their kinship.

Roces (2000) strongly argued that despite major gender equality milestones brought about by women power in the 1990s, cultural constructions of Filipino women changed very little. Education and marriage are still highly regarded as the best achievement of a woman, and regardless of educational attainment or class, marriage is the destiny of every Filipino woman. Women who remain single or not attached to men are regarded as either “suspect”, that is, a witch, or incomplete, that is, an “old maid” because they have failed the purpose of their existence (Eviota, 1994). Feminist scholars argued that intermarried Filipino women leave the Philippines not only to improve economic status but also to satisfy the traditional constructions of a Filipina. The definition of a Filipino woman is interchangeable with her multiple roles as a wife and mother, plus in kinship as sister and daughter. Her main concern remains managing household affairs, family and kin group needs, and organising the family’s

economic, social, spiritual and physical wellbeing. It appears to be the same in Australia (Roces, 2000).

### **The Filipino Elderly**

In the Philippines, classification of people according to chronological age is widely recognised because the social responsibility and expectations of an individual is relative to their age (Jocano, 2002). In addition, as discussed earlier, the older the generation, the higher the position in the hierarchy, with younger generations expected to defer to, care for and respect the older ones. Therefore, the aged have not been seen as posing as a problem for the Philippine society.

According to some authors, classification of the elderly by self-assessment of their own health shows a clear bias toward those with poor health receiving more support (Domingo, 1987; Medina, 2001). This behavioural pattern may be attributed to adherence to norms of filial obligation and providing support to parents in their old age. Economically, the three typical sources of economic security of the Filipino elderly in the Philippines are their own gainful work, their families and the pension system. Literature indicated that most elderly Filipinos co-reside with other members of the family or kinship system. Domingo's (1990) study showed, in general, that old people are integrated with the families of their married children especially with the daughters. However, some people do not live in the same house but still maintain their old residence while receiving some economic and psychological support from their children. This benefit is not unidirectional as more than half of those who live with their children reported providing financial support to them. Thus, the study highlighted benefits of this type of living arrangement for both children and the elderly. The old are able to function as babysitters; reciprocally, other family members are available to care for the elderly.



Williams and Domingo (1993) conducted a study on the social status of elderly women and men within the Filipino family. In this study they focused on the decision-making power of elderly Filipinos within the family in the Philippines. They conducted a household-level survey of the elderly aged 60 and over. They interviewed 729 (55.2%) women and 592 (44.8%) men, 50.5% were from urban areas. They found that elderly participants who were in good health and/or younger elderly who were employed, well-educated, and own their home, those who provide economic transfers to children, and those in more frequent contact with children (although not actually living with their children) tend to be more influential in family decisions than older elderly, those who are not highly educated, those who are no longer in the labour force, those who do not provide economic support to their children, and those with infrequent contact with children. (p. 424). It would be interesting to note how pre-migration social status of migrant women like the Filipino women in this report impact of their health and well being as they age in Australia.

### **Filipino Values**

Jocano's (2002) ethnographic study showed that many urban family values and practices continue to reflect rural-based values and practices because many of the contemporary urban residents are from rural areas. Jocano argued that there are only two major sources of differences between Filipino ethnic groups, religion (Christianity and Islam) and language (regional languages). A review of literature indicated that despite emerging changes in the kinship structure, the Filipino family continues to provide reciprocal physical and psychological protection and support, a sense of belonging and source of strength. Aside from economic contribution and as main source of emotional support, women continue to care for the sick and ageing members of the Filipino family. Jocano strongly contended that despite rapid changes sweeping the country, these changes are mostly in material aspects (attire, houses, food, communication and entertainment technology) and that basic institutions

of kinship and the family are not adversely affected. The less affected are the core values and norms like *hiya* (sensitivity, shame), *pakikisama* (mateship), and *utang-na-loob* (reciprocity, in-debt gratitude) that continue to influence local ways of thinking, believing, feeling, and behaviour. Filial piety is the sibling's way of repaying debts of gratitude to the parents. *Hiya* is closely related to *mukha* (face). Losing face is a big disappointment or disgrace to the family.

*Barkada* or *samahan* represents the peer group, which may be a professional organisation, a college association, or a loosely organised group of friends. Jocano (2002) argued that it was from this unit that an individual derives psychological and economic support outside the kinship domain. It would be interesting to note what would be akin to *samahan* for Filipinos to other countries. In Australia, evidence appears to point to ethnic community associations, social or sports clubs as a way of showing *samahan*. For the aged population, aged care services support activities like Drop-in or Physical Activity Group at day care centres provide opportunities for the formation of *samahan*.

### **Ageing in the Philippines**

The prevailing view in the research community is that the country is still young. Unlike most countries, however, the ageing population in the Philippines is increasing rapidly from 5.2% of the total population in 1980 to 5.8% in 1998 (Carlos, 1999). This increase poses as a big challenge for policymakers, service providers and governments, as to the family. The concerns identified that important considerations included security in old age, elderly abuse, health, gender imbalance, and the economic impact of ageing on overall welfare.

Natividad (2000) highlighted that parents do not usually incur *utang-na-loob* from their children. It is the children who have the duty to show respect and obedience and care for their elderly parents because of filial duty and *utang-na-loob*. However, Natividad found in the 1996 Philippine Elderly Survey that 92.5% of the participants who had grandchildren

regularly cared for them. Further, that the urban elderly show higher reliance on their children for economic support; the rural elderly rely on earnings from agricultural production.

Department of Social Welfare and Development (DSWD, 1992) programs for the elderly include training, program development, licensing and accreditation of welfare agencies such as publicly and privately managed homes for the aged and the elderly volunteer program. The senior citizens are also entitled to privileges and benefits that include discounts on transport fares, medicine, and recreational or entertainment; free medical and dental services in government agencies; and free access to certain socio-economic programs (Natividad, 2000). This initiative aimed at giving the ageing members of the community access to facilities with recreational, educational, health, spiritual services, and social programs designed to assist them to achieve a more productive, healthy and satisfying life (DSWD, 1992; Natividad, 2000). Another initiative is to provide training for elderly health workers in poor urban areas to become “community gerontologists”. The elderly are trained in massage, reflexology, herbal medicine, basic assessment and checking vital statistics. The volunteer community gerontologist keeps records of elderly people in the area and encourages them to have regular check-ups with doctors and in hospitals. This is an innovative community initiative that appears to be relevant, responsive and appropriate for elderly residents particularly in the poor urban areas of the Philippines where economic insecurity is a barrier to access to health services. Given the disparity of standards in government and service regulations particularly on health among countries of eastern and western orientations, it would be interesting to note the equivalent of this initiative for elderly Filipinos residing outside the Philippines.

Literature indicated that many of the volunteer programs for elderly people in the Philippines are not too dissimilar to those of other countries like Australia. However, the

initiatives for grandparents are of particular interest to the current study because of the Filipino grandparents who migrated in old age to look after their grandchildren in Australia.

### **Gendered Migration of Filipinos**

The increasingly gendered nature of international migration has attracted media, government and non-government attention. Scholars and activists from diverse ideological and theoretical viewpoints have focused this gendered migration phenomenon producing robust and at times controversial literature. However, Piper (2003) argued that scholars investigating women's patterns of migration typically discuss women as either migrants or "brides" for marriage or overseas contract workers (OCWs). As mentioned earlier, since the 1970s, the Philippines is one principal source of migrants with these patterns of migration. According to Asis (2006), in the last 30 years, a "culture of migration" of Filipinos has become apparent as many were motivated to work or migrate overseas despite adjustment problems, risks and vulnerabilities that might confront them. Higher educated and white-collar groups moved to the USA, while blue-collar workers moved to the Middle East. Medina (1993) attributed this variation to the differing needs of receiving countries. Since 1981, Filipino women have outnumbered men in international migration for both family or bride/spouse migration. Since 1992, they have migrated as newly hired contract workers. Most female OCWs were in the domestic and entertainment industries, followed by factory, sales and nursing (Holroyd, Taylor-Piliae, & Twinn, 2003). McKay (2003) argued that the increasing rates of international intercultural marriages are associated with increasing flows of female contract migrant workers. Regardless of motivation to migrate or category of visa, evidence shows that migrant women generally face particular challenges or vulnerabilities.

### **Filipinos in Australia**

Australia has been one of these western countries that have received Filipino migrants for work or migration purposes. However, there has been scarcity of literature available in

Australia on this group of migrants. These few studies have focused mainly on Filipino women in cross-cultural marriage (Cahill, 1990; Chuah et al., 1987; Kelaheer, Potts et al., 2001) as “mail-order brides” and victims of domestic violence (Cunneen & Stubbs, 1997; Kelaheer, Williams et al., 2001a; Kelaheer et al., 1999; Woelz-Stirling et al., 1998), marital conflict and finances (Woelz-Stirling et al., 2000), social and cultural context of mental health (Thompson et al., 2002), and health service utilisation (Kelaheer et al., 2003). Other studies have focused on the loneliness and quality of life of older Filipino migrants (Butler, 2002; San Jose, 1995), grandparenting and cultural identity (Torres-D’Mello, 2003, D’Mello & Esmaguél, 1990), and state-based community studies (Hennessy, 2004; Soriano, 1995; Zubiri, D’Mello, Esmaguél, & Wilks, 2010).

Older Filipino women have typically migrated at retirement age to help families in Australia by looking after the grandchildren so that their parents could participate in paid employment. However, anecdotal evidence from community leaders has shown that there were concerns for some elderly grandmothers, who despite physical and health decline, were still involved in primary caregiving, thereby becoming potentially socially isolated in the host country. Another concern expressed by the leaders was that many Filipino women in intermarriage were balancing roles as wife and caregiver for their much older Australian husbands. It raised more concerns for these women who were residing in regional or remote areas of Australia where services are generally more limited and the social network weak.

### **“Brides”**

For the purposes of this research, the term “brides” is used to refer to women who were born overseas and entered Australia as a fiancée or spouse of a Philippines-born male or a non-Filipino Australian man. The union between those from the same cultural backgrounds is referred to as intramarriage, while the union between interracial, international, intercultural, and mixed marriages is referred to as intermarriage. Through job recruitment

agencies, introduction agencies, and networks of women already abroad, international romance has developed. The term, “mail-order brides” has been widely used in media and literature to refer to women who engaged in intermarriage particularly in western countries like Australia. However, this label has been associated with negative portrayals of the media of overseas-born women married to Australian men.

One of the sources of overseas-born women for marriage was the Philippines. It is widely highlighted in Filipino migration history as the “mail-order bride” phenomenon in the 1980s to countries like Canada (Lusis, 2005; McKay, 2003; Philippine Women Centre of British Columbia (PWCBC), 2000), Australia (Cahill, 1990; DIMIA, 2003; Iredale et al., 1992; Jackson & Flores, 1989; Kelaher, Williams et al., 2001a; Kelaher et al., 1999; Woelz-Stirling et al., 2000), Japan (Suzuki, 2003), the USA (Del Rosario, 2005) and Europe. This was fuelled by booming economies and modern technologies that influenced an increase in international transactions between continents, regions and countries; and the same “push factors” that compelled overseas workers to work in other countries. Filipino women settled in countries like Japan and Germany through intermarriage or initially work-related migration. Hence, a discussion on “brides” at the end of this chapter gives an overview of the available literature on Filipino migrants in Canada, the USA, Japan and Australia. These countries were selected, as they have been traditional migration countries for Filipino women, particularly brides in international, interracial, intercultural or mixed marriages.

Another group of Filipino women who migrated for marriage were the spouses of Filipino men who migrated to Australia. However, although this group of women did not attract the attention of media or policymakers, they were included in the current study. It was envisioned that there would be differences between the two groups of migration for marriage in the acculturation level, perceived social support, and coping strategies utilised to adapt to

challenges in Australia. The groups of young adult Filipino women who migrated for marriage were followed by the group of old age Filipino grandmothers.

### **Grandmothers**

Aside from Filipino brides, there have been even fewer studies on Filipino migrants who came under different circumstances, such as grandmothers, under the Australian Immigration Family Reunion Program in the 1970s (Butler, 2002; D'Mello & Esmaguél, 1990; San Jose, 1995). The group of grandmothers who migrated when they were already old migrated mostly to care for their grandchildren. Adjustment to and coping with a new life can be an enormous task at an age when physical and functional abilities are beginning to decline. For some, there is a sense of optimism joining their child in the new country but some also feel a sense of loss and sadness about leaving extended family (Butler, 2002) and uncertainty in the new country (Torres-D'Mello, 2003). Studies indicate that they are likely to experience isolation, language and cultural barriers, intergenerational conflict and dependency (Butler, 2002; Thomas, 1999, 2003b, 2004; Hugo & Thomas, 2002; Thomas & Balnaves, 1993).

Torres-D'Mello (2003), Butler (2002) and San Jose (1995) highlighted the family as the main source of support for this small community. A study on the subjective report on the quality of life of older Filipino migrants by Butler (2002), the needs analysis on elderly Filipino consumers by San Jose (1995) and anecdotal evidence from health service providers indicate that old Filipinos rely heavily on family support. A small number of Filipino elderly live alone in the community without support. These findings were supported by a recent study by Kelaher, Williams et al., (2001b) on population characteristics, health and social issues of Filipino women in Queensland. The effects of informal caregiving have been widely documented. Literature showed that caregivers often faced physical, mental, social and financial strain while they provide informal care (Tang, Ryburn, Doyle, & Wells, 2010). Caregivers of all ages reported experiencing sleep problems, weight loss, anxiety and

depression, chronic illness, and poor quality of life compared to non-caregivers. What would be the challenges for the many older Filipino women who migrated in the 1970s and 1980s to care for their grandchildren in Australia so that adult parents could be in paid employment? Many of these aged women settled in isolated suburbs and had no access to public transportation or adults to talk to for most of the time. Moreover, they experienced language problems in communicating with the children and their neighbours. These issues posed a challenge for the community as well as policymakers and service providers. Hence, this current study devoted a small part of the preliminary phase to exploring the caregiving experiences of this migrant group, and are reported in Chapter 6.

### **“Mail-order Bride” Phenomenon**

#### **Filipinas in Canada.**

Earlier studies on Filipino migrants focused more on general Filipino population demographic profiles in the 1970s. This was followed in the 1980s to early 1990s by issues on labour market, growth of the community and community organisations, and the migrant social network. From the late 1990s to mid 2000s, studies focused on labour market integration rather than settlement, secondary migration and rural-urban linkages.

Lusis (2005) conducted an extensive review of literature about Filipino migrants in Canada and discovered the literature shared distinct characteristics such as urban bias, emphasis on economic integration, and gender bias. He conceded, however, that, as of 2001, 43% of Filipino migrants live in the Greater Toronto area and that academics have greater access to community organisations in the urban centre hence it is understandable therefore that the focus was on Filipinos in the urban centre of Toronto and Vancouver. The literature showed that for many Filipino migrants, the main motivation to work in Canada was to send remittances back home to support their families in the Philippines. Filipino women were highly represented in the Live in Carer Program (LCP) and racial stereotyping shows



economic and social consequences for the Filipino women. He noted applicants of equivalent educational qualifications from Europe and the Philippines were given different types of employment by recruitment agencies, with Europeans assessed as professionals or nannies and Filipinas as servants or housekeepers. The Philippine Women's Centre (PWCBC) conducted a community-based research study, which showed that Filipinas who were widely known as domestic workers from the 1980s, were coming to be known as "mail-order brides" from the 1990s (PWCBC, 2000).

Literature suggested that for various reasons such as de-skilling, low pay and economic insecurity, some women working as contract domestic workers were pushed toward international marriages. Poverty in the third-world country pushed some women to marry Canadian nationals they met through match-making agencies, friends and work (Lusis, 2005; McKay, 2003). The women used the various forms of migration categories such as family strategy, reunification, marriage, or contract work to migrate to Canada. They left jobs as nurses, teachers, bank clerks and accountants to get contract jobs abroad to provide for family and reduce economic insecurity but many of them were not in paid employment. Those who were employed had lowly paid jobs and mainly worked in service sector. Thus, contrary to their expectations, many became economically dependent, and some also experienced emotional and physical abuse on top of being marginalised and de-skilled. Lusis also found social networks to be paramount in the social and economic integration of Filipino migrants in Canada. These networks initially provided a newly arrived migrant with housing and/or assisted in finding a job. However, researchers also found a hierarchical system that seemed to be a reflection of the social condition in the Philippines. Literature showed that landed migrants (e.g. independent immigrants, sponsored relatives under the family reunification program) within the Filipino community in Vancouver looked down on Filipinos employed as domestic workers.

Research conducted by Oxman-Martinez, Hanley and Cheung (2004) support previous findings. Many Filipinas who entered intercultural marriages via contract work in Canada married older men who were separated or divorced. The domestic worker Filipinas were aware that their non-Filipino husbands stereotypically had the perception that they were domesticated, subservient and faithful. The Filipina's main motivation in marrying a non-Filipino man is to achieve freedom and independence rather than financial security, which they could achieve by continuing contract work. Many did not marry high-income-earning Canadians and continued to work after marriage partly to continue to send remittances to support their families in the Philippines. However, for some participants, the transition from domestic worker to wife and recognised professional worker in the mainstream Canadian labour market was not always successful.

In summary, the literature on Filipino women migrants in Canada highlighted (Lusis, 2005; McKay, 2003) that domestic workers and "mail-order brides" were forced to confront differences between social, regional, cultural and economic class among Filipino migrant communities in Canada in addition to potentially experiencing segregation and discrimination by non-Filipino Canadians and being placed in the lower level of the Filipino society's hierarchical social class.

### **Filipinas in the United States of America.**

Northern America, popularly referred to as the USA or America, has attracted many Filipino nationals since the 1900s (Gordon, 2005). There was a dramatic increase after the 1965 amendments to the American Immigration Law, which allowed American nationals to sponsor their relatives to migrate to America. Females accounted for 55% of migrants to the USA from 1930 to the late 1970s, while the number of males exceeded females from 1982 to 1988, reversed again, favouring females from 1989.

Del Rosario (2005) noted that the Filipino migration to America started in the early 1900s with Filipino males filling labour gaps in pineapple fields and apple orchards in Guam, Hawaii and California. They were prevented from marrying American women and many lived in isolation. From the 1970s, Filipino migrants to the USA have been categorised as ethnic Asian Americans. The flow has continued despite a pull from other booming economies in the Middle East, the Gulf region, Canada, Japan, Singapore and Hong Kong, including a period of phenomenal migration of Filipino women for intermarriage. Del Rosario argued from an historical-cultural approach that gives equal emphasis to America and the Philippines. She investigated the bridal diaspora by interviewing 10 Filipino women migrants married to American men. She found “internet-mediated” marriages as a new phenomenon among Filipino women migrating to USA. All of the Filipino women she interviewed were professionals with long-term careers and were predominantly from middle class backgrounds. She argued that the historical relationships between USA and the Philippines as well as the perception USA as the “land of milk and honey” contributed to the Filipino women’s preference to migrate to the USA and marriage as the “most efficient route” to meet the Filipino woman’s individual needs (e.g. career development, financial security) as well the needs of the family of origin.

### **Filipinas in Japan.**

Depopulation in rural or agricultural areas, a shortage of young Japanese women, an ageing population, and cultural maintenance appear to have encouraged Japan to invite international migration by importing labour and brides. Scholars were interested in examining the magnitude of the influence of other Asian women on Japan’s society (Burgess, 2004; Cahill, 1990; Nakamatsu, 2003; Piper, 2003; Suzuki, 2003).

In the early 1980s, Asian women were usually categorised as “entertainers”. By late 1980s, they were called “urban entertainers” or “rural brides”. In the Philippines, Filipino

“entertainers” in Japan became commonly referred to as “*Japayukis*” (Roces, 2000). This trend was followed by a significant trend commonly referred to as “*Aja no hanayome*” (Asian brides) (Burgess, 2004; Nakamatsu, 2003; Suzuki, 2003). Brides initially came from Thailand, Sri Lanka and the Philippines, followed by South Korea, China and recently Russia. In recent years, international marriages have increased considerably with 1 in 22 of all marriages involving non-Japanese, representing a 500% increase in international marriage in 20 years (Burgess, 2004). Contrary to the mainstream notion and despite persistent stereotyping of Filipino women as “Filipino brides”, Filipinas comprised only a third of the non-Japanese brides, with Chinese and Korean accounting for the majority.

Asian migrant women realised that they lost their usual social resources when they migrated to Japan. The losses included loss of identity, lack of competence and knowledge in the new culture. They had low status roles as wives and mothers – and brides have a very low standing in Japanese society. However, Burgess (2004) noted that rather than rejecting these low status domestic roles, the migrant *hanayome* realised that the initiatives have to come from their internal resources and adopted long-term active strategies to change their circumstances. These strategies include extending their involvement outside the confines of domestic and economic realms by establishing network connections, and educating other *hanayome women* and Japanese society through cultural presentations. Although the women were still reporting being marginalised and discriminated at work, home, and by governments, because of their ethnicity, language, and socio-cultural background, Nakamatsu (2003) strongly argued that the results demonstrated that Asian *hanayome* women were autonomous and strategic in participating in marriage introduction, and in negotiating reproductive and productive roles in the host country. Like many other *hanayome* women, many Filipinas used the intermarriage strategy to leave the Philippines where they may have been enduring economic hardship and/or biased social structure in order to have a better life.

Nakamatsu (2003), Piper (2003), Suzuki (2003) and Burgess (2004) attempted to use the gendered approach to emphasise the role of migrant women as active agents of change rather than offer the stereotypical portrayal of migrant women, particularly foreign brides, as vulnerable victims of gender and sexual norms in the host country. They attempted to shift the usual feminist paradigm in classifying *hanayome* women as “victims” of patriarchal commodification and objectification of women to “negotiators” to reinvent themselves and actively fulfill their roles as wives, workers, and as new citizens. Suzuki’s (2003) article focused on an ethnographic vignette specifically looking at the narratives of Filipina *hanayome* in rural Japan from the mid 1980s to early 2000s and attempted to question certain feminist and popular portrayals of *hanayome* in Japan. She found that earlier representation of Filipina *hanayome* in Japan in the 1980s continues to the present. Filipina *hanayome* were still presented as subordinate, oppressed, sexually subjugated and socio-economic victims in their relationships because of their gender, nationality, stereotypically assumed class, and third-world poverty. Suzuki challenged the enduring myth that all Filipina *hanayome* wished to enjoy an affective and affluent lifestyle by being dependent on “wealthy Japanese”. She also noted that very little attention was accorded to them as active agents of change. She added that choices and practices that Filipina *hanayome* made indicate that they were also redefining their identities not just as stereotypically labelled prostituted and victimised wives or *hanayome* and mothers, but as self-determined active agents in economic sector and family unit of Japanese society.

### **Filipinas in Australia.**

From the 1970s to 1980s a significant number of young women migrated as fiancées and spouses of Australian men. Many brides settled in rural areas of Australia with many experiencing negative stereotyping on arrival on top of the adjustment challenges new migrants typically encounter as they settle in another country (Cabigon, 1995; Cahill, 1990).

Literature shows that migrant women generally have less work participation, fewer social networks, and lower use of health services despite high needs, and are geographically distanced from ethnic networks particularly in rural areas (Thomas, 1992, 1989). In addition, as discussed in the previous chapter, the health of women in rural and remote areas is generally poorer compared with their urban counterparts. It raises a concern for the health and welfare of isolated intermarried Filipino women migrants in rural areas as they approach ageing with limited ethnic networks and have been a stereotyped minority or labelled “mail-order brides”. Rowland (1986) suggested that the ethnic aged in Australia may face the dual challenges of ageing and being a member of ethnic group. Filipino women in rural and remote areas are arguably in double jeopardy as ageing members of an ethnic minority population.

As stated earlier, the literature search for documented information on the Filipino community in Australia has shown that the Filipino migrants are an under researched group and thus there are currently limited studies on Filipinos’ adjustment and health in Australia (Kelaher, Williams et al., 2001a, 200b; Kelaher et al., 2003; Thompson et al., 2002; Torres-D’Mello, 2003; Butler, 2002; San Jose, 1995; Small, Lumley, & Yelland, 2003; Small, Rice, Yelland, & Lumley, 1999), and the few that have been conducted have focused mainly on violence against Filipino women in intermarriage relationships (for example, Cahill, 1990; Chuah et al., 1987; Cunneen & Stubbs, 1997; Easteal, 1996; Woelz-Stirling et al., 1998).

While Filipino women in Australia share many of the experiences of other migrant women, such as settlement problems, isolation, high unemployment or underemployment, and a lack of knowledge about and access to legal rights and social support services, there are particular features that make Filipinas especially vulnerable. Their vulnerability to domestic violence arises from how their marriages were contracted and the stereotyping of Asian

women generally, and of Filipino women particularly, as compliant and subservient (Cunneen & Stubbs, 1997).

One might expect to find the same problems confronting women from other cultural groups who marry men under similar circumstances. For 1989–1992 the annualised rate of homicide for all women in Australia aged between 20 and 39 was found to be 1.0 per 1000,000. The rate for Philippines-born women was 5.6 per 1000,000. Between 1980 and 1994, the Human Rights Commission referred to 26 deaths or disappearance of Filipino women. According to Cunneen and Stubbs (1997), although the violence against Filipino women can be regarded at one level as male violence against women, on another level it appears to reflect male fantasies of Filipino women as ‘racialised and sexualised’ in the media and introduction agencies. They found that Filipino women in Australia were nearly six times more likely to be victims of homicide compared to Australian women. The stereotypical representations of the Filipino women, social disapproval of these intermarriages, and the consequential shame these women experienced contributed to the underreporting of domestic abuse and access to services (Woelz-Stirling et al., 1998).

Cooke (1986) interviewed 104 Filipino women in Manila prior to their departure for Australia, and 30 Australian husbands of Filipino women residing in Australia. The results challenged the popular views that a large proportion of intermarriages were through marriage agencies and that most women were bar girls or prostitutes. Cooke found that only 30% of women met their husbands through introduction agencies and most of the women were from administrative or professional occupations. The study by Chuah and colleagues (1987) investigated the “mail-order brides” problem in Australia. The study challenged the common view that marriage by correspondence, particularly between Australian men and Filipinas, is prone to high levels of domestic abuse and marital breakdown. The researchers found that these forms of intermarriages attracted wide attention because of their novelty and not

because of factual evidence. Additionally, they strongly argued that culture was used to express the objection to inter-racial marriage when it was more about the racist assumption that intermarriage was not natural. Other studies have supported Chuah's challenge. Jackson and Flores (1989) found that Filipino-Australian marriages were no more prone to marital breakdown than any other marriages, and the findings by Kelaher and colleagues (1997) suggested that health outcomes for Filipino women in intermarriage were better than those of their counterparts in certain areas. They have fewer difficulties in settlement, were more likely to speak English well and were able to draw on the social resources of their husbands.

Cahill's (1990) pioneering study of Filipino women married to Australian, Japanese and Swiss men found that international marriage appealed to women as an opportunity to reinvent themselves as affluent middle-class overseas with better life for the women who believed this was less attainable in their countries of origin. The desire for a better life included positive images of marriage, a caring husband, children, financial security, and personal career advancement.

Cahill (1990) conducted a cross-national study comparing Filipino women's intermarriages in Switzerland, Japan and Australia and to identify important factors for successful adjustments to marriage to a non-Filipino husband and to the new environment in the host country. The results contradicted the four common assumptions about Filipino women in intermarriage: Most Filipino women in intermarriage were "mail-order brides", bar girls or prostitutes, poorly educated from poor areas in the Philippines, and settled in remote areas in the host countries. Cahill found similar results to Cooke and Chuah's studies that the minority of the Filipino women met their husbands through match-making agencies, and for those who did, the marriages were not loveless as popularly assumed. Cahill also found notable differences between Filipino-Filipino intramarriage and Filipino-Australian intermarriage. Many of the Filipino intermarriages were in rural and mining areas while



Filipino intramarriages were in urban areas. Many of the intermarried Filipino women did not have children while almost all of the intramarried women in his study had children. Cahill also noted that several women in the intermarriage group were widowed but given no support by their husband's families.

A study by Kelaher, Potts et al. (2001) found that intermarried Filipino women, with an average age of 30 years, were usually educated, while their Australian husbands, with an average of 40 years, were less educated; studies found that this group of Filipino women had a difficult period of settlement. The stigma attached to being stereotyped "mail-order bride" influenced their reluctance to seek support and access appropriate community services. It can be inferred therefore that these women's exposure to generic life stressors are exacerbated by experience of discrimination as a stereotyped ethnic minority (Myers, Lewis & Parker-Dominguez, 2003). The study of Kelaher, Williams et al. (2001a) on the other hand found that Filipino women in intermarriages appear to experience less stress in adapting to Australia, fewer problems with health and accessing health services, suggesting that intercultural relationships may also facilitate acculturation. They also found that women's expectations of infrastructure, population distribution and lifestyle were influenced by the women's social status and where they originated from in the Philippines.

Given the results of various studies on Filipino women and the response by both Australian and Philippine governments to tighten the regulations on introduction agencies, serial sponsorships, and domestic violence, Saroca (2006) found that the identity of Filipino women had remained racialised and sexualised as "brides" or "mail-order brides". Another challenge that Filipino women migrants had confronted in Australia was access to preventive measures and utilisation of health services for cultural or linguistic reasons. This challenge would be greater for Filipino women, particularly those who settled in rural and remote areas. Although Kelaher and colleagues (2003) found no differences between women living in rural

and remote areas of Queensland in terms of consumer knowledge about services, these women had more problems in having their information needs met compared to those living in other parts of the state. The differences in the utilisation of health services were primarily associated with structural limitations in the services and the women's inability to take time off from work. Access to mental health services was another issue for this migrant group. Thompson and colleagues (2002) found that mental illness was still highly stigmatised and the absence of close family ties added to the emotional problems of the Filipino women. In addition to the loss of these ties, their emotional distress was associated with the maladaptive transition from collectivist Philippine society to an individualist Australian society.

The review of the few major scientific studies on migrant Filipino women showed a need to explore the impact of their migration and settlement experiences on their mental health as they approach old age in Australia.

## **Chapter 4: Theoretical Background**

A review of literature on migration, culture and mental health has emphasised that gender, age at migration, marital status, pre-migration experiences, culture, values, beliefs, and appraisal of stress and coping, significantly impact on an individual migrant's settlement, acculturation and adjustment to the new country, their health status, participation in workforce, financial abilities, social support and pattern of service use (Kimbrow, 2009; Liang & Bogat, 1994; Thomas, 2003a, 2004; Thomas & Balnaves, 1993). This chapter will now focus on the various theoretical frameworks that are relevant to these variables addressed in this study.

### **Cross-cultural and Indigenous Psychology**

Psycho-social theory is widely accepted as a framework for understanding the changes in biological, psychological and societal systems that bring about changes in humans. The approach emphasises the continuous interaction of the individual and the social environment at each life stage (Newman & Newman, 2003). Psycho-social theory addresses the life span from infancy through to very old age. It assumes that people have the capacity for self-regulation (to integrate, organise and conceptualise their experiences in order to protect themselves and cope with challenges); and that culture actively influences individual growth at each life stage. Cultural goals and societal expectations and demands trigger reactions for the individual, which then influence certain individual capabilities to be developed further. The current study is focused on the last three life stages: middle adulthood, later adulthood and very old age. This study is interested in the person–environment fit and adaptability in middle adulthood, redirecting energy toward new roles in later adulthood, and coping with ageing and social support in very old age. To ascertain this, this chapter will focus first on global theoretical concepts on Berry's (2008) acculturation model, the psycho-social approach to studying the interaction between individual migrants' needs, abilities, societal

expectations and demands from middle adulthood (for the purpose of the current study adjusted to 40 years to 60 years) through to later adulthood (60 to 75 years) and very old age (75 years and older). This is followed by a discussion on the different models of stress and coping (e.g. Selye, 1956; Freund & Baltes, 1998; Baltes & Baltes, 1990; Hobfoll, 1989; Lazarus, 1966), and a focus on the constructs that are particular to migrants such as stress, culture, acculturation, social support, psychological health, gender and caregiving. Wong's (1993) resource-congruence model of successful adaptation to stressors will be the primary model of stress examined in more detail at the end of this chapter. Wong's model is an expanded multicultural model of Lazarus' stress and coping model (Lazarus & Folkman, 1984; Lazarus, 2000).

### **Acculturation Model**

Based on Berry and Kim's model (1988), individuals who undergo acculturation can be grouped into five acculturating groups according to the level of voluntariness involved, the presence or absence of movement and the permanence of contact. These five acculturating groups are immigrants, refugees, native peoples, sojourners (temporary residents) and ethnic groups. Immigrants, ethnic groups and sojourners are distinguished by voluntary contact, while refugees and native peoples are identified by involuntary contact. With regard to movement, immigrants, refugees and sojourners are distinguished by migration, whereas native peoples and ethnic groups are sedentary. In regards to the permanence of contact, sojourners are distinguished by temporary contact whereas all other groups establish relatively permanent settlement (Berry & Kim, 1988).

The majority studies on acculturation have been conducted on populations who experience voluntary migration or sedentary contact, with a strong emphasis in the literature on migrants. Migrants are generally regarded as being drawn from their homeland by attractive forces while refugees are viewed as being pushed out of their homeland (Kosic,

2004). These differences in motivation may influence their adjustment to life in their new country of residence (Mauro, Sato & Tucker, 1992; Thomas & Balnaves, 1993). Morrison (1973) added that voluntary migration as a motivator is directly related to the vulnerability of mental health after migration.

According to Kosic (2004) studies on migrants' acculturation have concentrated on the role of two groups of factors: (1) features of the original and host countries or societies and (2) individual characteristics of the migrant. The societal features include cultural, economic, political and social, while the individual characteristics include demographic variables (such as age, gender, marital status, education, length of residency), personality characteristics (e.g. self-esteem, locus of control) and socio-cognitive and motivational factors (e.g. coping strategies, acculturation strategies, social support and cognitive closure). The current study is focused on the relationship between demographic variables (age, gender, marital status, education, length of stay, caregiving role), motivational variables (marriage or grandparenting), cognitive strategies, acculturation strategies and social support.

Acculturation is based on the attitudes of individuals towards the maintenance of their original culture and attitudes towards group interrelationships with the host culture (Berry, Poortinga, Segall, & Dasen, 2002; Berry, Trimble, & Olmedo, 1986). Some have defined acculturation as changes in behaviour and values (Marin, Sabogal, Marin, Otero-Sabogal, & Perez-Stable, 1987) or movement from the social behaviours and values of one culture to another (Mavreas, Bebbington, & Der, 1989). These changes can be bi-directional, occurring in both the dominant cultural group and the non-dominant group. Typically the dominant group strongly influences the non-dominant group to adopt the norms, values and behaviours (Berry, 2008). The acculturation process also requires the individual to integrate the values of the host culture and one's own migrant group. It is the individual migrant in the diasporic migrant community in the host culture (Bhatia & Ram, 2001a). Studies show that the process

of acculturation impacts on the mental health, socio-cognitive functioning, and general wellbeing in acculturating individuals (Dyal & Dyal, 1981; Kosic, 2004; LaFromboise, Coleman, & Gerton, 1993). Different models and theories representing two different theoretical frameworks (assimilation and bicultural/alternation) have been developed to describe the psychological processes, socio-cultural experiences, and challenges associated with acculturation (Dyal & Dyal, 1981; LaFromboise et al., 1993). According to both, theoretical framework acculturation deals with two criteria: (a) whether or not the acculturating individual or group wishes to maintain their cultural identity, and (b) whether or not a positive relationship with the dominant culture will be established (Dona & Berry, 1994). Berry used these two criteria to create a four-category typology of acculturation processes in developing a model that has been widely recognised in the literature on acculturation (Berry, Kim, Power, Young, & Bujaki, 1989).

**Berry's acculturation model: Acculturation strategies.**

Berry (1990, 2008) proposed a classic model of four possible acculturation attitudes or strategies adopted by migrants. These strategies are described as marginalisation, separation, assimilation and integration. Figure 6 illustrates these two-dimensional formulations of acculturation strategies. Literature showed that each of these acculturation strategies impacts on mental health and adaptation in very different ways (Berry et al., 2002; Kosic, 2004; Mio, Barker-Hackett, & Tumambing, 2006; Ramos, 2005). The characteristics and impacts of these four strategies will be described, and examples of empirical research into the impacts of these different modes of acculturation will be reviewed.

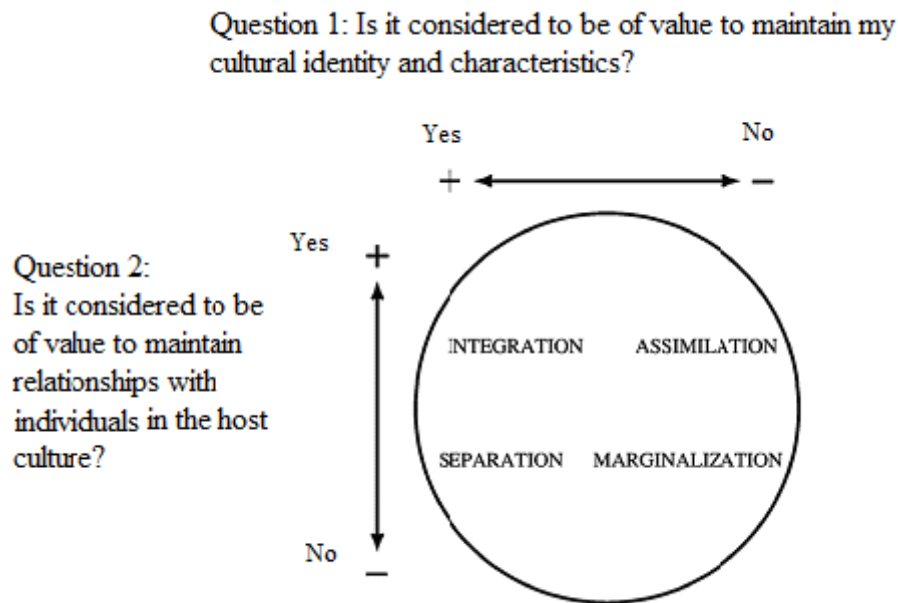


Figure 6. Berry's two-dimensional formulation of acculturation attitudes  
Adapted from Berry (2008, p. 332).

With few exceptions (e.g. Sam, 1999, 2001) several studies have found that migrants normally indicate integration as their most preferred strategy and marginalisation as the least preferred strategy (Berry, 1997; Sam, 1995; Van Oudenhoven, Prins, & Buunk, 1998). Several studies have also found that in terms of psychological adaptation, integration is the most adaptive strategy, and marginalisation as the least adaptive strategy (Berry & Sam, 1997). When it comes to the relative effectiveness of the other two strategies (i.e. assimilation and separation) with respect to adaptation, the general finding is that assimilation is better than separation, but may depend on its context (Birman, 1994; Thuen & Sam, 1994). Another study found that the effect of choosing assimilation is negative for high self-monitoring migrants and positive for low self-monitoring ones, while the positive effect of choosing integration is stronger for high self-monitoring migrants than for low self-monitoring ones (Kosic, Mannetti, & Sam, 2006). The choice of an acculturation strategy also depends on a number of factors including the social (e.g. cultural distance, immigration policy in the host

society), socio-demographic (e.g. age, gender, level of education, length of residence), and the individual (e.g. cognitive and personality characteristics). Many studies on migrant acculturation attitudes and adaptation strategies seldom explored the role of individual differences and personal and social resources in adapting to migration under different migration circumstances within ethnic groups. This current study therefore examined the relationship between Filipino migrants' adaptation using Berry's acculturation strategy model (Berry, 1997, 2003) and their coping resources following Wong's resource-congruence model of adaptation (Wong, 1993, Wong & Ujimoto, 1998; Wong & Wong, 2006).

### ***Assimilation.***

The assimilation strategy is when an individual seeks interaction with the host culture but does not wish to maintain their cultural identity (Berry & Kim, 1988; Berry, Phinney, Sam, & Vedder, 2006). The individual gives up their identity or origin in favour of identifying with the host culture's values and beliefs (Mio et al, 2006). Assimilation has also been referred to as "high acculturation" by other researchers investigating attitudes toward acculturation (Miranda & Umhoefer, 1998; Ramos, 2005). Traditionally, this approach was once viewed as a desirable form of acculturation, based on the belief that an individual will suffer from isolation and a sense of alienation until they have been accepted into the dominant culture (LaFromboise et al., 1993). However, there is growing evidence to show that high levels of acculturation can have a damaging impact on the mental health and socio-cultural experiences of assimilating individuals. Those who chose to assimilate risked being criticised by members of their ethno-cultural group, and failing to be fully accepted by members of the dominant culture (LaFromboise et al., 1993; Arroyo & Zigler, 1995; Fordham, 1988). Individuals who preferred assimilation but lacked the tools necessary for effective participation in the dominant society often suffered impaired mental health as a consequence (Beiser, 1980; Beiser et al., 1981).



Other studies have found that increasing levels of assimilation are associated with negative health behaviours and psychological harms (Koneru, Weisman de Mamani, Flynn, & Betancourt, 2007; Rogler, Cortes, & Malgady, 1991). There is anecdotal evidence that intermarried Filipino women in regional or isolated areas were observed to uncharacteristically consume alcohol regularly and engage in gambling, suggesting that assimilation and/or alienation from traditional social support networks are risk factors for increasing negative health behaviours and decreasing mental health (Wilks, 2005).

### ***Separation.***

The separation or segregation acculturation strategy occurs when an individual does not display aspiration to relate to the dominant society and chooses to maintain their original cultural identity and traditions. These individuals are described as “low acculturation” individuals (Ramos, 2005) and reject all the host culture’s values and beliefs (Mio et al., 2006). These low acculturation individuals perceive the new cultural environment as unfamiliar, intimidating and confusing (Miranda & Umhoefer, 1998) and tend to withdraw from the host culture’s practices. Research has found that segregation can lead to social isolation and depressive symptoms due to the difficulty associated with managing an unpredictable mainstream environment (Ramos, 2005).

For example, the results of the study by Smokowski, David-Ferdon and Stroupe (2009) showed that low acculturation was a risk factor for higher levels of fear, victimisation and being bullied in minority adolescents. Furthermore, low acculturation served as a protective factor against dating violence victimisation for Latino youth. It must be noted that this study was conducted on a minority population of adolescents in America, and so cannot be automatically generalised to other populations. While the separation approach to acculturation appears to lead to problems such as acculturative stress, it may be beneficial to some individuals in certain cases. Research by Berry and colleagues (2006) suggested

acculturative stress was beneficial when individuals were living within their own ethnic community within the host society. While both of these examples of studies indicate that there are positive aspects of separation, they also suggest that the separation strategy can impact negatively on socio-cultural experiences of acculturating individuals.

***Marginalisation.***

Marginalisation is when there is little or no interest in maintaining the original cultural identity and values and little interest in interacting with the dominant society. The individual does not identify with either the original culture or host culture (Mio et al., 2006). This acculturation strategy is associated with the highest levels of acculturative stress, anxiety and confusion, both collectively and individually (Berry et al., 1989). Marginalised groups lose social and cultural contact with both their traditional culture and the new dominant culture and consequently experience feelings of alienation and loss of identity (Berry et al., 1989).

For example, a large international study by Berry and colleagues (2006) investigated the relationship between how youth acculturate and how well they adapt. They found that individuals who showed a low ethnic identity and a low national identity were uncertain about their place in society, and reported more perceived discrimination, poorer psychological adaptation and poorer socio-cultural adaptation than any other acculturation profile. These findings regarding the maladaptive consequences of marginalisation were supported in many other studies (Castillo, Conoley, & Brossart, 2004; Choi, Miller, & Wilbur, 2009; Roccas, Horenczyk, & Schwartz, 2000). A cross-sectional study of subgroups of Korean migrant women aged 20–64 years was conducted by Choi and colleagues (2009) to identify their acculturation levels and to determine whether these subgroups differed on depressive symptoms in 200 Korean immigrant women aged 20–64. They found that the women in the marginalised subgroup reported significantly higher depression scores than the

women in the American and Korean clusters. These studies highlighted the importance of identifying migrants who do not relate to either their heritage culture or the new host culture in order to address their mental health risks.

### ***Integration.***

This acculturation strategy is also known as “biculturalism” whereby an individual combines aspects of their own culture and the host culture. An integrationist individual can gain competence and enjoy a sense of belonging in two different cultures, without losing their sense of cultural identity. It is argued that this mode of acculturation is the least detrimental to mental health and socio-cultural functioning of acculturating individuals (Miranda & Umhoefer, 1998).

For example, Miranda and Umhoefer (1998) investigated differences in self-reported depression and social interest in Latinos who were experiencing different stages of acculturation. The results showed that bicultural Latinos scored significantly higher on social interest, and obtained significantly lower scores on depression, compared with low and high acculturation groups. It must be noted that this study was conducted on a Latino migrant population only, and therefore cannot be automatically generalised to other minority populations. In addition, only self-report measures were used in gathering data, which might affect reliability of the responses. However, given these limitations, Miranda and Umhoefer’s study still provides an important contribution to the growing literature, which suggests that the integration mode is the acculturation strategy that is most beneficial to the mental health and adaptation of acculturating individuals.

Reviewing the study by Liu (2007) revealed that the integration strategy is the most preferred acculturation mode by the Asian participants in Brisbane, Australia because it gives them opportunities to maintain their ethnic cultural values and behaviours and at the same time develop a positive relationship with the society of settlement. An interesting finding is

the higher rating on separation strategy by Asians who consider multiculturalism as a moderate threat. Although they stand out as a group due to their physical appearance, the Asians also view multiculturalism as a benefit while the Anglo-Australian group view multiculturalism as a threat to their cultural identity. This difference may pose a challenge for policymakers and service providers. When the threat is perceived as low, the need to adhere to one's own ethnic group for support is also less. Limitations of this study include falling into the trap of aggregating all Asian groups into one, not collecting the motivation for migration, and collecting data from urban areas only. However, Bhatia and Ram (2001b) queried what hyphenated identities such as Asian-American or African-American means in the bigger society. They argued that bicultural competence or the four acculturation strategies proposed by Berry (1997) had some conceptual problems. They claimed that the process to achieve integration as the end goal was not explained and it failed to discuss the effects of conflict, power and asymmetry on diasporic migrants' acculturation process. They argued that integration as the end point ignores the constant negotiation with old and new environments.

In summary, the review of literature showed that migrants may experience challenges that cause them varying levels of distress while adjusting to a new culture. This situation is widely known as acculturative stress. Acculturative stress is a response by individuals to life events that caused difficulties in the process of acculturation and is inversely related to the psychological and physical wellbeing of the migrant (Berry, 1998; Berry et al., 2002). These responses often include high levels of depression because of culture loss, and of anxiety because of uncertainty about how the individual should live in the new environment. The cause of difficulty may be associated with the dominant culture (e.g. stereotyping, discrimination) or in the non-dominant culture (e.g. lack of resources like education, language to adapt to the new situation).

Literature indicated that marginalisation is associated with poor social adaptation and higher psychological distress than any other mode. Assimilation and separation are also associated with psychological distress. However, the relationship between low acculturation and wellbeing does not appear to be a simple, linear relationship, as there is research to suggest that low acculturated individuals may benefit from mediating effects of traditional cultural values and social support (Smokowski et al., 2009). Research suggested that biculturalism serves as a protective factor that buffers acculturative stress, and is associated with improved mental health and enhanced socio-cognitive functioning, compared with low or high acculturation (Bacallao & Smokowski, 2005). The following section will review the literature investigating the relationships between acculturation strategies and how well individuals adapt to their acculturation experience. As discussed, there is considerable evidence to suggest that of the four proposed acculturation attitudes, biculturalism/integration is associated with the healthiest levels of mental health (Dona & Berry, 1994; Miranda & Umhoefer, 1998; Ramos, 2005). The next section will review the literature investigating the relationships between acculturation and various aspects of psychological adaptation.

### **Acculturation and Mental Health**

One key dimension that underlies acculturation strategies is the degree to which groups and individuals maintain or change their customs and beliefs (Berry et al., 2002). At a group level, the contact between a dominant and non-dominant culture has been described in various terms such as westernisation, modernisation or industrialisation (Berry et al., 2002), but these descriptions have been too general to use in cross-cultural psychology (Kagitcibasi, 1990). At an individual level, the behavioural aspects or changes have two components: culture shredding and culture learning (Berry, 1992). Culture shredding is the purposeful or accidental loss of existing cultural or behavioural aspects over time, while culture learning involves intentional or fortuitous acquisition of new ways to behave in the new setting.

Culture shredding and culture learning processes are often selective. As individuals get in contact with the new setting, variable patterns of change and maintenance emerge resulting in cultural diversity.

Table 3

*Factors at Group and Individual Levels Affecting Acculturative Stress and Adaptation*

<b>Variables</b>	<b>Factors</b>
Group Level	Individual Level
Society of origin	Ethnographic characteristics (e.g. language, religion, values) Political context (e.g. civil war, repression) Economic conditions (e.g. poverty, disparity) Demographic factors (e.g. crowding, over population)
Society of settlement	Immigration history and policy Attitudes towards immigration Attitudes towards ethnic groups Social support availability and usefulness/appropriateness
Group acculturation	Changes in acculturating group Geographical (e.g. rural to urban) Economic (e.g. loss of status) Social (e.g. isolation) Cultural (e.g. dress, food, language) Biological (e.g. nutrition, disease)
Moderating factors Prior to acculturation	Demographic (e.g. age, gender, education) Cultural (e.g. language, religion, distance) Economic status Health Migration motivation (e.g. pull/push) Expectations
Moderating factors During acculturation	Acculturation strategies Contact discrepancy or participation Social support appraisal and use Societal attitudes and reaction (prejudice and discrimination) Coping strategies and resources

(Adapted from Berry et al., 2006, p. 363.)

Table 3 shows the specific factors at group and individual levels affecting the process of acculturation and adaptation. These factors include personal resources such as fluency in

the host language and ethnic identity and positive attitudes towards migration, as well as social resources such as family and ethnic community support and positive reception by the host society. The availability of these resources, together with socio-demographic characteristics such as age, gender, education and ethnicity, influence the settlement experience and risk of mental health problems.

The process of psychological acculturation begins with group acculturation and individual acculturation experiences and results in long-term adaptation. The process is influenced by moderating factors that already present prior to acculturation (e.g. public policies of the host society) and those that arise during the process of acculturation. These moderating factors are important for both the acculturating group and the individual. Depending on their levels, these moderating factors may be appraised as both risk (stressor) and protective (opportunity) factors. Related to acculturation modes are coping strategies individuals use to deal with the experiences that were appraised as challenging or problematic. The concepts of stress and coping will be discussed in detail in the later part of this chapter with particular emphasis on Lazarus and Folkman's model (1984) and its expanded multicultural version by Wong (1993, 1998).

The following factors can influence the course of acculturation: gender (Hamid, Simmonds, & Bowles, 2009), education (Jayasuriya, Sang, & Fielding, 1992), status loss and status mobility (Aycan & Berry, 1996), cultural distance (Ward & Kennedy, 1992), reasons for migration (Richmond, 1993), personal factors such as age (Kimbrow, 2009), and personality (Kwon, 2002). Some scholars have argued that it is not the personality trait but the fit with the new societal environment that affects the acculturation process (Berry et al., 2002). The length of acculturation also influences the course of acculturation and degree or level of problems (Enrile & Agabayani, 2007).

Suarez-Morales and Lopez (2009) highlight that there is very little empirical research into the relationships between acculturation, acculturative stress and anxiety. Instead, past research in this area has focused on depression and externalising problems. A study by Ramos (2005) investigated the relationship between various levels of acculturation and depression in Puerto Ricans in the USA. The results of the study found that low acculturation was associated with low positive affect in both men and women. This study employed a large sample size and used culturally robust measures appropriate for the sample.

The results of Ramos's study support the findings of Miranda and Umhoefer's (1998) study, which also concluded that individuals who were bicultural were less likely to experience depressive symptoms compared with low or highly acculturated individuals. For Asian Americans, some research showed they are not a homogenous group with regards to the status of mental health and acculturation. An extensive review of two decades of empirically based studies on depression in older Asian migrants in America showed that depression is prevalent among older Asian migrants, and that it is linked to gender, recency of migration, English language proficiency, acculturation, service barriers, health status, relationship with children and family and social supports (Kuo, Chong, & Joseph, 2008).

A large study on the Filipino migrants and mental health was conducted by Mossakowski (2003) in a large-scale cross-sectional epidemiological study of Filipino Americans ( $n = 2,109$ ) to examine if ethnic identity is linked to mental health and reduces the stress of discrimination. To address the limitations of previous studies on Asians and Filipino Americans in particular, Mossakowski used a three stage sampling procedure and conducted a face-to-face survey, using bilingual interviewers who were fluent in English and Tagalog or Ilocano. Mossakowski found that apart from Koreans, the Filipino Americans have the second highest levels of depression compared to other Asian Americans like Japanese and Chinese. Filipino women were more likely to report depressive symptoms. Those who were



never married or previously married women (separated, divorced, or widowed) had higher levels of depressive symptoms than married women. Philippine-born Filipino migrants reported lower depressive symptoms compared to their USA-born counterparts. Results also showed that being employed and being educated in the Philippines only was associated with better mental health. These differences in emotional wellbeing were attributed to differences in immigration history, modes of assimilation, levels of ethnic identification, and discriminatory experiences.

Mossakowski argued that variation may exist within a racial/ethnic group because members of the group do not necessarily share the same levels of ethnic identity. Ethnic identification according to Phinney (1991) involves having a sense of ethnic pride, involvement in ethnic practices (e.g. preparing and eating special food, playing ethnic music), and cultural commitment to one's racial/ethnic group that serves as a buffer against the detrimental impact of discrimination. Yet the same strong ethnic identification may intensify the stress of being different from the host or dominant culture thus emphasising the minority status. Mossakowski also argued that studying ethnic identity adds a socio-psychological dimension to the socio-cultural and cultural examination of the stress process.

A review of literature indicates that generally, biculturalism is associated with better psychological adaptation, and less acculturative stress. Specifically, bicultural individuals have been found to experience the lowest levels of depression compared with low and high acculturated individuals (Ramos, 2005). Self-esteem appears to be highest in bicultural individuals also; however, low acculturated individuals who take great pride in their traditional cultures and family background may also exhibit higher levels of self-esteem, especially when compared with assimilated individuals (Rogler et al., 1991). A review of the little research regarding anxiety and acculturation reveals a need for further research into this relationship.

In summary, a review of the research on the different acculturation strategies reveals that biculturalism/integration is consistently associated with better psychological and socio-cultural adaptation, compared with assimilation, separation and marginalisation approaches to acculturation. This finding is evident in studies on both migrant and refugee populations. While integration appears to be the most adaptive approach to acculturation, research suggests that both immigrants and refugees adopting a separation approach can in fact benefit from the mediating effects of traditional cultural values and social support, and exhibit higher self-esteem and moderately good psychological adaptation, compared with assimilation and marginalisation (Berry et al., 2006). However, research also indicates that separation attitudes are associated with poor socio-cultural adaptation (Berry et al., 2006; Miranda & Umhoefer, 1998). The overall research indicates that marginalisation is associated with the poorest levels of psychological and socio-cultural adaptation (Berry et al., 2006). Assimilation is generally associated with slightly better outcomes than marginalisation, but poorer than those associated with integration. However, further research investigating different populations like the Asian “mail-order brides” is required before we can generalise the results to other populations.

It is evident from the review that the vast majority of studies on acculturation have been performed in America and on migrant populations like Mexicans, South Americans and Asians. Bhatia and Ram (2001b) also queried what hyphenated identities such as Asian-American or African-American mean in the mainstream societies. Following the diaspora theory, Bhatia and Ram further argued that the acculturation process requires the individual to integrate the values of the host culture and one’s own migrant group. These observations strongly illustrate a need for studies employing Australian data, as well as a strong need for further research into the acculturation of various ethnic groups like the South East Asian populations, particularly that of Filipino “brides.” To improve the cultural adjustment of

overseas-born brides of Australian men, the current study aimed to focus on studying the acculturation patterns of Filipino migrant brides and investigating how these relate to adaptation in the new country.

### **Stress-coping Theories**

Coping is viewed as a stabilising factor, which may help individuals maintain psychosocial adaptation during stressful periods (Lazarus & Folkman, 1984). Roberts, Dunkle, and Haug (1994) stated that people face life events with psychological, physical and social resources, which reduce the adverse effects of stress on emotional wellbeing. Taft (1985) maintained that individuals develop attitudes and coping strategies that lead to varying personal adaptations when they are confronted by two cultures, their own and that of a new country. Enrile and Agbayani (2007) found that gender role expectation is associated with changes in core cultural values. Contrary to typical assumptions where the longer the migrant is in the new country, the more acculturated they become, the Filipinos in America did not follow this progression. Migrant and US-born Filipino women and migrant Filipino males showed more liberal attitudes toward women. Results also suggested that adjustment to the culture of the new country might require the maintaining of traditional values such as gender role expectations for the women to be caregivers in the family. As fewer resources are available to the older adults, particularly the elderly, their ability to reduce the effects of stress may be lessened, which places them at greater risk of poor mental health.

Several studies have shown that socio-demographic factors, family and social support and personality dispositions are useful contributors in predicting active and avoidance coping (Holahan & Moos, 1987; Thomas & Balnaves, 1993; Williams & Berry, 1991). Individuals who have more personal and environmental resources are found to rely more on active coping than avoidance coping. Levels of education, the ability to speak English and the length of residence are also found to be important indicators of wellbeing for migrants (Minas &

Hayes, 1994; Thomas & Balnaves, 1993; Tran, 1987). Scott and Scott (1985) found cultural skills to be important to migrants' social adaptation.

Lazarus and Folkman (1984) are recognised as having advanced the understanding of stress by considering both the person and the stressful event. From Lazarus and Folkman's transactional, cognitive-phenomenological perspective, the person's appraisal or evaluation of the nature of demands of an event, is considered to be more influential in the stress process than the objective characteristics of the event. They outlined two types of appraisals: primary and secondary. Primary appraisal can be considered central to an individual's perception of an event as stressful or threatening to wellbeing. Secondary appraisal happens when individuals consider their available options or resources for coping with the event. The study by Terry (1994) showed some support for Lazarus and Folkman's (1984) view that the nature of the event will be a less important predictor of coping than the person's appraisal of its nature and demands. Terry's results also suggested that there are both situational and stable influences on coping responses. Lang and Carstensen (1994) posited that perceived support, as opposed to received support, appears to be a critical predictor of mental health outcomes.

Kashima and Hardie (2002) recently proposed a tripartite model of self that is based on psycho-social theories of self. The model aimed to explicate the links between stress, coping and health. Their study showed that matched domains of self, uplifts and coping activities predicted multi-dimensional wellbeing, and that mismatch in these three domains led to physical and emotional ill being. Literature showed a relationship between acculturation strategies and coping strategies. For example on the study of the health of migrants in Germany, Schmitz (1992) found that integration is positively correlated with task orientation, segregation is positively correlated with emotion and avoidance coping, while assimilation is positively correlated with both task and emotional orientation.

Several studies in Australia (Thomas, 1991, 1992) have revealed that Vietnamese participants who reported more stressors were those who came under the Australian Family Migration program, spoke little English, and had to rely on their children for financial support. She argued that the differences between refugees and migrants could be made on the basis of their motivations to come to Australia. Roberts and colleagues (1994) found that stressful life events were due to frequent and recent physical health changes while Thomas and Balnaves (1993) found that the major sources of stress for elderly Vietnamese migrants in Australia were related to psychological and social resources, family relations, homesickness, social relations, language ability and financial dependence.

Ryff and Essex's (1992) study of relocation of older women suggested that social comparisons and reflected appraisal processes can have adaptive consequences for mental health in later life. They inferred that positive psychological functioning might be an antecedent as well as a consequence of the relocation experience. Although this study had exclusive reliance on self-reporting and there was possible construct overlap, the findings support the idea that wellbeing after relocation is linked to congruence between personal needs and what the new setting provides.

People face life events with psychological, physical and social resources that can reduce the adverse effects of stress on wellbeing (Reddy, et al. 2008; Thomas, 1999). Among the major life changes occurring in old age are physical and cognitive changes, retirement, and widowhood. As in earlier periods of life, these changes require adjustment, which sometimes can be easy or difficult. As fewer resources are available to the elderly, their ability to reduce the effects of stress may lessen, which places them at greater risk of poor mental health (Hugo & Thomas, 2002). It can be inferred therefore that adjustment to and coping with a new life, due to migration at old age, can be an enormous task during a time when physical and functional abilities are beginning to decline.

Following Wong and Ujimoto's (1998) resource-congruence model of adaptation, which is an adaptation of Lazarus and Folkman's (1984) transactional model of adjustment, stress and coping, it can be stated the effects of immigration may depend on individual motivation, and how the individual appraises the situation and copes with it. Literature also suggested that family, social support, culture and environment are important determinants of mental health particularly in the case of the older overseas-born migrants.

Migration to another country generally requires individuals to: (a) relinquish their roles and possessions; (b) forgo activities they may have performed all their lives; (c) accept a new environment that they may not be agreeable to; and (d) alter the contact they usually have with their families, friends, relatives and neighbours. Psychological stress, such as that caused by migration, can be defined as a particular relationship between the person and the environment, which is appraised by the person as taxing or exceeding their resources and endangering their wellbeing. Stress and coping approaches to psycho-social adjustment recognise the contribution of both the individual and the environment, and seek to understand the particular environment context and the personal skills and resources that facilitate or mediate for the best adjustment to the new country. A transactionist viewpoint also emphasises that the environment and person mutually affect one another for either good or for bad outcomes. Given the many factors influencing an older migrant from a culturally and linguistically different country, a review of literature point to models of investigating adjustment and coping that are multidimensional and also culture-bound.

The current study investigated differences between groups on their positive ageing and wellbeing, and the influence of various factors such as ageing, acculturation, coping and social support on their psychological health. It explored participants' appraisal of their coping resources and the buffering influences of family and social support, meaningful relationships and social support in their caregiving roles. The study endeavoured to identify

implications for clinical practice and further research on the psychology of ageing and cross-cultural adjustments of older migrants particularly from the South Eastern region of Asia.

In investigating the psycho-social resources, caregiving experience, and wellbeing of older Filipino groups in Australia, many factors need to be considered. Aside from demographics factors, particularly ageing, the following were investigated: their purpose for migration; their pre-migration expectations about Australia; acculturation; quality of their living experiences, which may be both stressful and pleasant; dimensions on their source and means of coping; varied factors associated with loneliness; perceived support of family; and participation in social groups.

Based on the review of literature on the problems faced by older migrants in adjustment to the host culture, it was expected that intramarried women, grandmothers and intermarried brides would report (1) higher acculturation, (2) higher stress, anxiety and depression, and (3) higher caregiving stress. It was also expected that the (4) older members of each group would show the greatest stress, anxiety and depression, and the lowest acculturation and perceived social support, and (5) women in regional and isolated areas would report the highest levels of stress, anxiety and depression, and the lowest use of problem-solving and the highest use of self-distraction, venting and substance use/pokies in coping with stressful life events.

Butler (2002) found that although the Australia group was deeply rooted in their previous culture, they were able to successfully adjust and acculturate in their new country of residence. This was contrary to expectations, compared to Philippines-resident counterparts. Their study showed that most elderly migrants from the Philippines have had great exposure to diverse cultures before migrating, have a good knowledge of the English language, believe they have solid family support, and participate in social and ethnic activities. These findings support previous studies (Mauro et al., 1992; Morrison, 1974; Thomas & Balnaves, 1993)

that have shown motivation and cognitive appraisal of coming to Australia for older and elderly migrants have had a great impact on adjustment to life in the new country. Thomas and Balnaves' (1993) study indicated that elderly migrants from non-English speaking backgrounds may experience a disproportionate share of problems faced by aged people in general, especially those of social isolation and homesickness. Other findings (Butler, 2002), however, suggested that strong family, social and community support, meaningful relationships and better physical environment facilitated good adjustment. They argued that the middle-aged and elderly Filipinos' appraisal of stress, ageing, migration, loneliness and coping may be linked to three sets of variables: (1) socio-cultural factors; (2) family support; (3) social and community resources. These results support Ryff and Essex's (1992) study that after relocating, wellbeing is linked to the congruence between personal needs and what the new setting provides and Wong and Ujimoto's (1998) resource-congruence model of adaptation for the Asian elderly. Cohen and Wills (1985) and Klimidis and Minas (1998) stated that social relationships may influence health and wellbeing in two major forms: main and buffering effects. Social networks are said to more likely to exhibit main effects, while social support would show buffering effects in conjunction with specific stressful events. Results of this study also support other studies that strongly argue that social support has a huge effect on wellbeing (Moos & Moos, 1987; Sugisawa, Liang, & Liu, 1994) as well as on the adjustment of the older migrant (Kim, 1999; Sah, 2000; Thomas & Balnaves, 1993).

### **Stress.**

"Stress" is a term that has been used loosely in everyday communication by different people and cultures to describe an experience, or different conditions, or situations. It has been defined in different ways and has been extensively studied using various theoretical approaches or disciplines (Gurung, 2006). Literature has also highlighted that different individuals and cultures have different notions or experiences associated with stress.



However, earlier researchers mainly used activation of human physiology (Cannon, 1929; Selye, 1956) as indicators of stress response. It was not until the 1960s that psychological components were included in the study of stress (Kaplan, 1983; Lazarus, 1966, 1984).

The stress and coping paradigm emerged after many years of research on people's environment. Researchers and theorists came to an agreement that the interaction between the person and the environment is dynamic. Conceptual models of stress and coping have focused on the context and the transaction between the two systems, *personal and environmental systems* (Lazarus & Folkman, 1984; Moos, 1984; Wong & Ujimoto, 1998). According to Chun, Moos, and Cronkite (2006), however, Moos' model showed more emphasis on both contextual factors and transactions between person and environment. Wong (1993) expanded this model with emphasis on cultural context. Chun et al. (2006) also argued that cultural hypotheses of stress and coping involve cultural differences in normative ways of coping due to differences between individualistic and collectivistic cultures in personality, appraisal, motivation, and coping goals. The personal system consists of an individual's personal characteristics and resources that may include personality traits, cognitive abilities, and social competence. The environment system is usually enduring aspects of the environment that can be from the social domain, physical domain, family, work, or resources. Ongoing stressors and resources may arise from the social climate, family, work, and other aspects of the environmental system. New and acute life events and interventions are considered transitory conditions. Individuals assess or appraise the level of threat or challenge of these transitory conditions and whether they have the appropriate or required personal or environmental resources to handle the situation. The type of coping strategies will depend on this appraisal, the success of which influences the individual's health and wellbeing.

Recent literature on stress and coping has shown increasing research on stress and coping in cultural contexts other than the western paradigm. Wong and Wong's (2006) recent review of literature in cross-cultural psychology on ethnic or cultural differences in coping indicates the studies mainly used white or Euro-American psychological theories, concepts, constructs, instruments, and standards for studying and investigating non Euro-American, indigenous or cultural groups. This finding supports other scholars' argument that investigation and comparison of human behaviour should be framed in a cultural context (Moos, 2002; Segall, Lonner, & Berry, 1998; Slavin, Rainer, McCreary, & Gowda, 1991; Wong, 1993).

There is also an increasing argument to conduct research on gender, health and stress as evidence that women and men may vary in exposure to and appraisal of psychological stress, their biological reaction to stress and the coping strategies that they use to manage stress. Health psychologists argued strongly that there should be more focus on women and stress since women usually survive and care for their partners, parents, friends and children. They argued further that certain socio-demographic variables such as social and material resources and ethnicity cut across and interact with the influences of gender.

### **Coping.**

"Coping" generally refers to a dynamic process that involves ongoing transactions where individuals aim to neutralise or reduce stress, and coping strategies or activities are aimed at reducing the individual's appraisal of the discrepancy between demands of the situation and the resources of the person. Human beings cope with stress through cognitive and behavioural transactions. People use different coping styles and coping strategies to try to manage the appraised discrepancy or incongruence between the demands of the situation and their resources.

### ***Coping styles and strategies.***

Coping styles are general predispositions that get used repeatedly in dealing with stress. The two basic coping styles are *approach coping* and *avoidant coping*. Approach coping styles have also been studied using different terminology such as monitoring (Miller, 1987), vigilance (Krohne, 1993), or problem-focused (Billings & Moos, 1984). The avoidant coping style received similar attention and has been termed as blunting (Miller, 1987), cognitive-avoidance (Krohne, 1993), and emotion-focused or appraisal-focused (Billings & Moos, 1984).

Coping strategies are the specific behaviours and psychological efforts people use to deal with stressful events. Researchers on coping have generally grouped normative coping approaches based on their functions and methods. According to Lazarus (1966), coping serves two main functions: it can change the problem causing the stress or it can modulate the emotional response to the problem.

Literature has shown coping styles and strategies influence mental health outcomes. *Problem-focused* or *action-oriented coping* (e.g. active coping, planning) is strongly associated with positive psychological outcomes. *Emotion-focused coping* (e.g. avoidance, self-blame) is associated with poorer mental health. Although conceptually distinct, both strategies are interdependent and work together in the coping process (Lazarus, 2000). Earlier work of Lazarus and Folkman (1984) focused mainly on problem-focused and emotion-focused coping strategies. Recently, however, Lazarus (2000) has given considerable attention to relational meaning which may be categorised as *relation-focused coping* (O'Brien & DeLongis, 1996). Inclusion of relation-focused coping shows a stronger acknowledgment that successful adaptation and positive outcomes are not only based on individual efforts but as well as, if not more importantly in some cultures, the other members of the individual's social network, both formal and informal.

Chun and colleagues (2006) argued that it is important to differentiate relation-focused coping whether it is collective or collectivistic coping. *Collective coping* refers to mobilising group resources, while the *collectivistic coping* style refers to the normative coping style of collectivistic individuals. Wong (1993) also argued that social support is different to collective coping. Collective coping is a concerted effort where every member of a group works to resolve the same problem. A member's problem is every member's problem and everyone is expected to find a solution. Social support on the other hand is when an individual gathers social support based on personal relationships. It is also expected that individuals in individualistic cultures use coping strategies that confront and change external stressors, and that individuals in collectivistic cultures are expected to employ coping strategies that avoid external stressors instead of modifying them.

Kuo (1995) found that on average Filipino Americans chose problem-focused coping more than Chinese, Japanese and Korean Americans. Among Asian groups, Filipino Americans were the least likely to choose emotion-focused coping. Lum (as cited in Bhatia & Ram, 2001) conducted an ethnographic study on how Chinese migrants use karaoke as a mean to establish and maintain their identity. Results showed that diasporic Chinese migrants in America use media such as television or the internet or karaoke in maintaining and establishing a relationship with the host culture and original culture. This is also true of many Filipino migrants around the globe, who use ethnic television programs like TFC and karaoke to establish and maintain their identity.

### ***Coping moderators and mediators.***

The coping process of dealing with a stressor may result in a preferred outcome (e.g. health and wellbeing) or unfavourable outcome (illness and unhappiness), which are influenced by many factors including individual differences. These individual differences and other salient factors that influence the coping process are called *moderators* or *mediators*. A

*moderator* changes the extent and/or direction of the relationship between the antecedent variable and outcome variable. Age, income and social support are examples of moderating variables. A *mediator* is the intervening process through which an antecedent variable influences an outcome variable. Coping behaviour and specific health behaviours are examples of mediating variables. An example of influence of a mediating variable is when a person changes sleeping or eating patterns in response to a stressor. Some moderators can also be mediators (e.g. exercise), but some moderators cannot be mediators such as age, ethnicity, race, or gender.

Social support refers to the presence of social and cultural institutions in the adjustment of the individual to a new culture (Williams & Berry, 1991). This includes ethnic associations (national and local), residential ethnic enclaves, extended families, availability of one's original group, and more formal institutions such as agencies and clinics. Social support is also defined as interpersonal transactions, which involve key elements such as aid, affect or affiliation, and has direct and moderating effects on health and subjective wellbeing (Antonucci, 1985; Ryff & Singer, 1996; Victorian Health Promotion Foundation, 1999; Vaillant, 2002). Literature highlights social support's influence in the acculturation process (Jayasuriya et al., 1992), indicating that supportive relationships with both cultures as the best predictor of successful adaptation (Berry, Kim, Minde, & Mok, 1987), while for some individuals social support from their heritage culture is associated with lower stress (Ward & Kennedy, 1993), but closer links with members of the society of settlement are most helpful when the individual's expectations are met (Berry & Kostavick, 1990). Several studies have documented the effects of the social support system on the wellbeing of the elderly generally (Koyano, Hashimoto, Kukawa, Shibata, & Gunji, 1994; Thomas & Balnaves, 1993); migrants (Moriarty & Butt, 2004); and the importance of family members in one's social support system (D'Mello & Esmaquel, 1990; Revicki & Mitchell, 1990; Thomas, 1993; Thomas &

Balnaves, 1993; Koyano et al., 1994; Minas & Hayes, 1994). Brewer (1991) also found that contact with those from the culture of origin reinforces a sense of identity when the situation outside the group is uncertain, stressful and competitive, and that one way to deal with the undesirable stigmatisation is to convert the stigma from a feature of personal identity to a basis of social identity.

Scott and Scott (1985) found that family solidarity before migration predicts people's satisfaction with the family in Australia and improves their overall emotional health, self-esteem, morale, and level of cultural competence. Family support has been found to be positively linked to active coping (Cronkite & Moos, 1984; Storer, 1985; Holahan & Moos, 1987; Minas & Hayes, 1994). Moos and Moos (1986) found that individuals with supportive family environments, characterised by high cohesion and expressiveness and low conflict, were associated with family members' better adjustment and greater ability in being able to deal with stress. Individuals who were part of a nuclear family unit felt more socially embedded than those who were not (Taft, 1973; Tran, 1987; Lang & Carstensen, 1994).

Some studies indicate that social support has an important effect on wellbeing (Moos & Moos, 1987) as well as adjustment in older migrants (Thomas & Balnaves, 1993). Holahan and Moos (1987) found that individuals with supportive environments tended to use less avoidance strategies than those who had lower levels of family support. Terry (1994) proposed that the presence of a supportive social network would allow for the provision of support and that people with access to such support would be more likely to seek it. Community associations, peers, and ethnic and cultural factors were found to have attenuating effects with Vietnamese elderly migrants coping with stress (Thomas & Balnaves, 1993).

However, other studies have reported findings contradictory to the above. The investigations by Revicki and Mitchell (1990) and Roberts and colleagues (1994) showed that

social support does not attenuate the importance of strain and stressful life events on wellbeing. The authors maintained that the measures used in later studies did not allow for determining whether specific types of support actually had beneficial effects. It is also not clear whether the support received by the oldest family member would significantly reduce or moderate the effects of strain.

While the importance of social support has been widely emphasised, in the study of the effects of the social network and social support on the mortality among old people in Japan, Sugisawa, Liang, and Liu (1994) found that statistically, social support had no effect on mortality. Cohen and Wills (1985) and Klimidis and Minas (1998) stated that social relationships may influence health and wellbeing in two major forms: main and buffering effects. Social networks are said to be more likely to exhibit main effects, while social support would show buffering effects in conjunction with specific stressful events. However, if family solidarity prior to migration forecasts wellbeing (Scott & Scott, 1985), and if older members (Ben-Porath, 1987) give up any attempt to acculturate, seeing this as the task of the younger generation, then this may precipitate intergenerational conflicts and the possible threat of losing mandated positions within the family and community (Thomas & Balnaves, 1993).

### ***Coping goals.***

Coping goals are also very important in the coping process and may vary across situations and people. Examples of such goals may include finding a new or better job, improving financial capacity, providing a better future or education for children, reuniting with family, or fixing a computer problem. Chun and colleagues (2006) argued that *coping goals* are influenced by cultural values and beliefs. However, they found that little consideration is given to individual and cultural variations in coping goals. They strongly proposed four variations of coping goals due to fundamental cultural and belief system

differences between individualistic and collectivistic cultures: (a) focusing on the needs of self versus the needs of others; (b) asserting autonomy and independence versus reinforcing relatedness and interdependence; (c) controlling external environment versus internal self; and (d) maximising gain versus minimising loss (p. 40).

Emphasis in past research was mainly on self-focused goals following individualistic values and assumptions; the individual's main coping goal is to meet their own needs by reducing their psychological distress rather than other-focused goals to meet the needs of others. Chun and colleagues (2006) argued that individuals can have both types of goals at the same time, with one more important than the other depending on the type of stressor and characteristics of the individual.

Researchers' studies on effective ways of coping assume the desired outcome would be a decrease in the distress level. However, Chun and others argued that, on the contrary, when self-sacrifice is involved, distress might increase rather than decrease, yet the desired outcome is still being achieved. When this is the case, researchers tend to assess the individual as having ineffective coping strategies although they achieved their desired outcome (Bjorck, Cuthbertson, Thurman, & Lee, 2001).

There is increasing focus on positive outcomes in life in studying coping. Results of Somerfield and McCrae's review of literature on research about coping indicate the variety of identified positive outcomes of coping. Themes include: growth in personal coping (Curbow, Somerfield, Baker, Wingard, & Legro, 1993) or functional coping (Holahan, Moos, & Schaefer, 1996); meaning making (Park & Folkman, 1997) or meaning-based coping (Folkman & Moskowitz, 2000); or benefit finding (Tennen & Affleck, 1999).

### **Measuring Stress and Coping**

There is an array of instruments to measure the different psychological and physical aspects of stress. Earlier instruments focused on major life events the most widely used of



which is the Holmes and Rahe (1967) Social Readjustment Rating Scale consisting of 43 negative and positive (e.g. marriage, vacation) life events. However, its popularity has diminished as it attracted some criticism on the lack evidence to indicate the connection between life events and illness, and that it does not differentiate between unresolved and resolved life events.

Earlier coping instruments mainly focused on problem-focused and emotion-focused ways of coping, and recently on relation-focused coping, at the expense of culturally specific strategies and resources. Like Carver (1997), Wong, Wong, and Scott (2006) proposed an investigation and inclusion of other coping strategies in different cultures, for example, personal transformation when the stressful situation is chronic and beyond personal control. They argued that compared to cognitive restructuring or reframing for a specific situation, personal transformation is typically a continuing holistic change process, thus the latter is more proactive and the former more reactive. They suggested that in transformational coping, an individual's subjective reaction to a problematic situation is altered. The problematic situation is transformed into a problem that can be solved through commitment, control, and challenge rather than change in one's fundamental attitudes, values, or philosophy in life.

Research has shown that small events or hassles (e.g. stuck in the traffic, noisy neighbour) negatively impact on a person's health and exacerbate or compound the effects of major life events (Weinberger, Hiner, & Tierney, 1987). Lazarus and associates developed a 117-item Hassles and Uplifts scale (Kanner, Coyne, Schaefer, & Lazarus, 1981), measuring small hassles, and the more commonly used Ways of Coping Questionnaire (WCQ) (Folkman & Lazarus, 1988), which was originally released earlier as Ways of Coping Checklist (Aldwin, Folkman, Schaefer, Coyne, & Lazarus, 1980). Carver, Scheier, and Weintraub (1989) then released the COPE inventory that included religion, and later added alcohol and humour, and a shorter version Brief-COPE. Hence, with the inclusion of these

three coping strategies that are particular to Filipino migrants and for its brevity, Brief-COPE was chosen for the current study. The relevant models of stress and coping are discussed in detail in the following section of this chapter, with particular emphasis on Resource-congruence model of coping by Wong (1993) and Wong and Ujimoto (1998).

### **Models of Stress and Coping**

Cannon's (1914, 1929) Flight or Fight Theory and Selye's (1956) General Adaptation Syndrome were the well recognised earlier theories of stress, and like early theories of stress, were based on physiological activation. Other later researchers on stress expanded and modified their models and included psychological components (Baltes & Baltes, 1999; Lazarus & Folkman, 1984; Kaplan, 1983; Lazarus, 1966; Slavin et al., 1991; Wong, 1993). The discussion in this chapter highlights the later theoretical models of stress that include individual and social resources, cultural, psychological, personal and environmental components of stress and the coping process.

#### **Cognitive appraisal model.**

Richard Lazarus (1966) is the proponent of the cognitive appraisal model of stress and coping, which is highly acclaimed as the first model of stress that included psychology. It has been the most widely accepted paradigm in studies of stress and coping. According to this model, stress is a dynamic process and defines stress as "external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1984, p. 52). Recently, however, Folkman and Moskowitz (2004) defined the coping process as the "thoughts and behaviours in managing internal and external demands of situations that are appraised as stressful" (p. 745). The later definition posits that stress stems from external situations like daily hassles or major life events. Other definitions of stress (Slavin et al., 1991; Wong, 1993) supported Lazarus's model's original position that the stress process starts with cognitive appraisal.

Chun and associates (2006) argued that *cognitive appraisal* of a potential stressor may be the most subjective part of the coping process. This appraisal can be *primary appraisal* of the potential negative impact (e.g. harm, loss, threat, challenge) of the event or situation, and then *secondary appraisal* of what can be done to cope with the event with available personal (e.g. intelligence, physical and mental health, cultural competence, religiosity) and social (e.g. finance, family, social support) resources.

*Harm/loss appraisal* and *threat appraisal* concern the negative impact of the stressor, while *threat* and *challenge appraisal* involve anticipatory appraisal even when harm or loss has occurred. Harm or loss appraisal is when actual damage to a person's physical, psychological or both are present. The difference between threat appraisal and challenge appraisal is the *focus* on either negative impact or loss for threat and positive growth or gain for challenge resulting from the stressor that has already happened. Challenge appraisal appears to be more pertinent to the sample in the current study as also highlighted in a previous study by Bjorck and associates (2001) on ethnic differences in stress appraisals in Euro-American, Korean-American, and Filipino-American college students. They found that contrary to their expectations, Korean- and Filipino-American students appraised stressors as more challenging and used religious coping more than their Euro-American counterparts. Personal cultural values of religiosity and presenting themselves positively to people who are considered to be authority figures, such as researchers, were the possible explanations for their presentation. Literature on Korean-American and Filipino-American cultural groups indicated that both show strong religiosity and spirituality.

### **Multicultural model of stress response.**

An extension of Lazarus and Folkman's cognitive model of stress and coping was proposed by Slavin and colleagues (1991). They proposed a *multicultural* model of stress process. They extended the cognitive model of stress process by adding social environmental

factors and their effects on human functioning. Specifically, they identified cultural dimensions such as minority status, discrimination, socio-economic status, race or ethnicity, age, gender, or culturally specific customs as pertinent factors influencing each component of stress model.

The five components of the stress response model are: (1) the types and frequency of events experienced, (2) appraisals of the stressfulness of the events, (3) appraisals of available resources, (4) selection of coping strategies, and (5) manifestations of adaptational difficulties. Under this model, the cultural interpretation of events based on individual or family or societal levels also influences or modifies primary appraisal, secondary appraisal, coping efforts, and final outcomes. It also emphasises that cultural groups who have closer family ties and active social support can influence secondary appraisals in the stress-coping process. This multicultural model of stress theoretically appears innovative in adding cultural factors that include family factors and social support but a review of literature showed very limited use of this model in empirical research.

### **Selection optimization compensation (SOC) model.**

One developmental model that has increasingly been cited in successful ageing research is the Selection, Optimization, and Compensation model (Baltes & Baltes, 1999; Freund & Baltes, 1998). The model focuses on goal setting and achieving behaviours that lead to healthier functioning in older adults. It posits that people confront the challenges of balancing and matching a variety of opportunities with fluctuations in resources over the life span. They argue further that at every period or stage of life there are limited resources (e.g. money, time, energy) to address all the opportunities they confront. In later adulthood it was expected that a person may want the opportunity to continue to work but the loss of a resource (e.g. physical health) may make it difficult for the person to continue working.

According to the SOC model, adaptation requires integration of the three processes: Selection, Optimization and Compensation (Newman & Newman, 2003).

Selection involves identifying opportunities or domains of activities that are of greatest value or importance. Selection consists of both elective and loss-based selection. Elective selection involves the selection and adjustment of goals. Priorities are identified based on individual abilities, physical health, environmental demands and individual preferences. Loss-based selection is a reaction to a loss of means or resources to effectively pursue all desired goals. This process is more salient as an individual ages and normal age-related losses occur. Optimization means allocating and refining resources in order to achieve higher levels of functioning in the selected domains. Optimization is the enhancement of existing resources in order to achieve goals. This can be done by obtaining new knowledge, developing new skills and learning from other successful forms of optimization. Compensation is the development of alternative ways of meeting desired goals.

The processes of goal selection and goal attainment are key factors that influence successful outcomes in ageing. As discussed earlier, it is expected that older adults confront changes in personal or internal resources (e.g. energy, cognitive ability) and external or environmental resources (e.g. financial, social, housing) as they age. They may have more time but they may have declining physical health and fewer financial resources. According to the SOC model, demographic factors on their own are not sufficient predictors of life satisfaction. Wellbeing is influenced by the person's ability to manage or reduce the impact of stressful life events using their resources to enable them to continue to engage in valued roles and activities. According to SOC model, the more an individual selects, optimises and compensates, the more likely they are to demonstrate healthy functioning in many areas of their lives.

Theoretically, SOC appears to show strong causal relationships between SOC variables and successful ageing. However, limited research was correlational in nature and therefore unable to provide a causal relationship (Freund & Baltes, 1998; Abraham & Hansson, 1995) and limited relationship with successful ageing (Cahill, 2002). Cahill also found no gender differences in the reported use of SOC strategies.

### **Conservation of resources (COR) model.**

The conservation of resources (COR) theory is a motivational theory based on the principal tenet that individuals strive to obtain, retain, foster and protect resources. Another factor in the stress and coping paradigm is the concept of congruence that Stevan Hobfoll (1989, 1998, 2001) emphasised. In COR the lack of fit between demands and coping resources influences the individual's appraisal and management of stress. The basic tenet of COR is that an individual has both innate and learnt drive to create, foster, conserve and protect the quality and quantity of their resources. Resources have intrinsic or instrumental value and may include objects (e.g. car, house), conditions (e.g. parental role, social networks), personal resources and energy resources. Resources that are paramount to survival and wellbeing such as food, shelter, health, attachment to significant others such as family, and psychological resources such as self-esteem, self-efficacy and optimism are key to resource management and maintenance.

According to the COR theory, stress occurs under three conditions or principles (Gorgievski & Hobfoll, 2008): (1) when individuals' key resources are threatened with loss, (2) when resources are lost, or (3) when individuals fail to gain resources following significant resource investment. According to COR principle 1, resources loss is disproportionately more salient than resources gain. This means that real or anticipated resources loss has stronger motivational power than expected resource gain. Resource loss is usually associated with negative emotions and impaired mental health. This loss then

influences impairment in mental and physical health. Loss experiences are expected to direct avoidance and loss prevention strategies rather than inspire a creative search for new opportunities to gain resources. In the COR model the environment may actively need to highlight the individual's strengths and encourage them to strive to gain resources when confronted with significant threats and losses. The second COR principle states that the individual must invest in resources in order to protect against resources loss, recover from losses and gain new and old resources. Individuals must have the personal and environmental capacity to invest in resources to ensure and augment engaging resources gain processes. According to this COR principle, those with greater resources are less vulnerable to resources loss and more capable of resources gain. The third COR principle emphasises the process of motivation and stress as akin to the loss and gain cycle. The fewer the resources as they lose resources, the less capable they are of dealing with further threats to resources loss. The loss cycles move more quickly than the gain cycles and have a stronger impact on health and wellbeing.

The COR model has been widely used in the study of the process of burnout and stress in organisational settings (Geller, Hobfoll, & Dunahoo, 2009; Gorgievski & Hobfoll, 2008). There has been adaptation of the resource congruence principles in other later models of stress and coping theories. However, and the model by Ujimoto and Wong (1993) was chosen for its relevance to the current study as highlighted at the following discussion on the model.

### **Resource-Congruence Model of Coping.**

Paul Wong is one of the early coping theorists who strongly argued the significance of *cultural context* in coping as demonstrated in the *resource-congruence* model of adaptation (Wong, 1993) and in the contingency model of cultural competencies (Leong & Wong, 2003). These models suggest that coping efficacy depends on (a) sufficient coping resources,

(b) multicultural competencies of what works in what situations, and what coping goals are valued in which culture, and (c) the selection of coping goals and responses that are appropriate to the situation and the cultural context (Wong, et al., 2006, p.20).

According to the resource-congruence model (Wong, 1993; Wong & Ujimoto, 1998), stress is an interactive process between resources and stressors that occur in appraisal, coping and outcome. Stress takes place in a cultural context. Wong and Ujimoto argued that problems do not always result from person–environment interactions but also from an individual’s inner conflict in the appraisal of the interaction between available resources and potential stressors.

Wong (1993) proposed that *successful adaptation* starts with the development of various types of *personal resources* and moves through the process in anticipation of potential problems or stressors; this shift is called proactive coping in contrast to typical reactive coping. The development of resources could come from learning from experience and research; relating by making friends, networks, building communities, helping others; and increasing inner resources, such as mental and spiritual health.

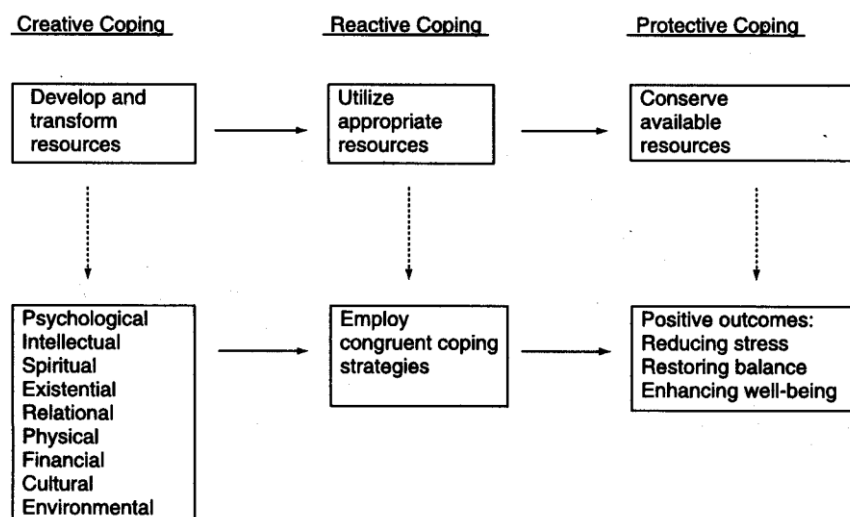


Figure 7. A schematic presentation of the resource-congruence model of effective coping (Adapted from Wong, Recker, & Peacock, 2006, p. 235).



The resource-congruence model shown in Figure 7 predicts that when individuals are faced with a stressful encounter, they will rationally assess their resources and the nature of the stressors, then use appropriate coping strategies. Once successful, they are able to relax and conserve resources. The key to successful adaptation, whether it is adjusting to ageing or to a new culture, is to develop and maintain a sufficient stock of resources.

Like Lazarus (1966), Wong and associates also proposed a two-stage model of appraisal (Peacock, Wong, & Recker, 1993): primary appraisal and secondary appraisal. *Primary appraisal* is the initial assessment of the situation whether it is potentially stressful. *Secondary appraisal* is assessment of coping options according to an individual's *coping schema* of what strategies work in what type of situation. They further posited that the coping schema is based on coping knowledge that has been influenced by previous coping experience in a certain cultural context. Apart from cognitive appraisal, the model also proposed existential coping. It involves acceptance of what the individual cannot change and finding positive meaning in a stressful event.

Wong also proposed the concept of *transformational coping* rather than the widely used instrumental coping in western psychology. The various forms of transformation include but are not limited to spiritual transformation, Buddhist enlightenment, the Taoist way of nature, and existential coping. Instrumental coping aims to resolve the problem or change the situation that is causing stress, while transformation is more likely to succeed when the problem is pervasive and beyond the individual or society's control. *Collective coping* may be more applicable in collective cultures or in adapting to major events like the recent tsunami in Asia.

The topic of *religion* and *spirituality* has attracted attention in cultural research in recent years (Bond, 2004; Folkman & Moskowitz, 2004; Klassen, McDonald, & James, 2006; Pergament, 2011). Bond's study on dimensions of social axioms and their correlates in

41 cultures showed that religion is a major component across cultures, varying only in how it is manifested or expressed, whether atheistic, agnostic, or theistic. Researchers (Klassen et al., 2006; Pergament, Koenig, Tarakeshwar, & Hahn, 2004) showed that religious beliefs facilitate adaptation to various circumstances. For the sample in this study of Filipino migrants, as shown in Chapter 2, when religion is a major fundamental element in their culture, it is imperative that the theoretical model and research instruments chosen for the study should include religion.

As highlighted in the review of literature, stress and coping models that mainly use Euro-American values and instruments are not always relevant to other cultures, thus lacking in construct equivalence. Further, many models of coping include only a limited group of cultural elements and exclude religion as an important factor (Slavin et al., 1991). On the other hand, Slavin and associates and Wong (1993) enhanced the more Euro-centric Lazarus and Folkman model by including socio-environmental components of stress and coping. However, Wong's adaptation model appeared to be more relevant to the purpose and sample in the current study. Wong emphasised indigenous cultural aspects like religious orientation, which has shown to be fundamental to across cultures (Bond, 2004), and to Filipinos in particular (Butler, 2002; Domingo, 1994; D'Mello & Esmaguél, 1990; Jocano, 2002; Medina, 2001; Rocés, 2003; San Jose, 1995). Wong (2006) also referred to transformational coping whereby an individual's subjective reaction to a problematic situation is altered. The problematic situation is transformed into a problem that can be solved through commitment, control, and challenge rather than changing one's fundamental attitudes, values, or philosophy in life. Thus, Wong's model was adapted for this study.

Wong and Ujimoto (1998) argued that most of the potential stressors for the Asian elderly are either intrapersonal (e.g. conflicts between traditional values and the host society) or interpersonal (e.g. relating to mainstream society because of language and/or cultural

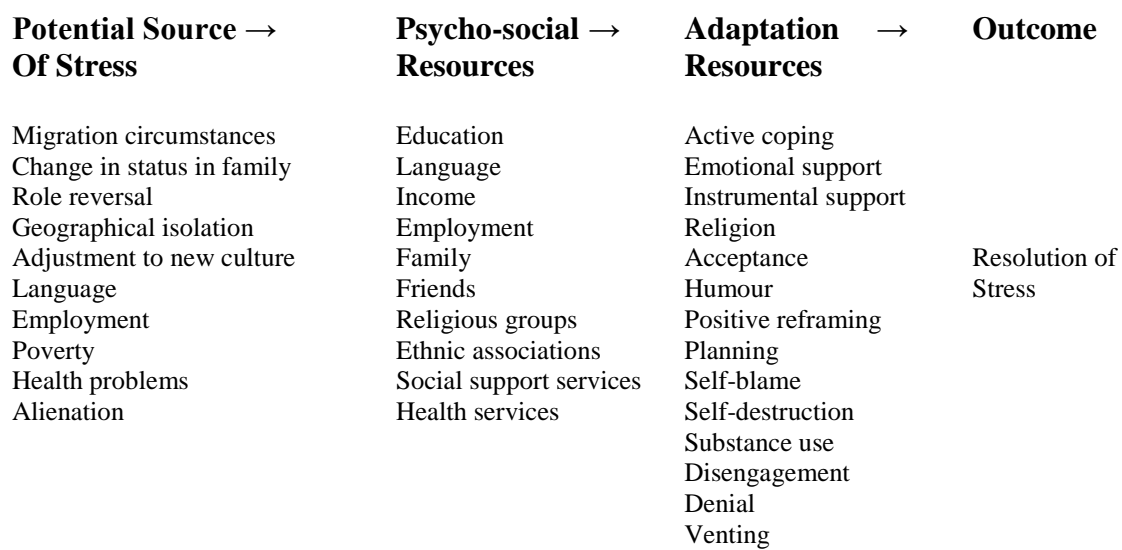
barriers). Reviews of the vast amount of literature on the stress and coping paradigm increasingly emphasise that coping depends not only on appraisal of stress but equally the appraisal of resources, and the importance of culture, resource congruence, and the lack of fit between demands and coping resources. This incongruence or lack of fit influences the individual's appraisal and management of stress (Kuo, 2010). Based on the various models discussed above, Wong's (1993) resource-congruence model of adaptation stands out to be the most relevant for the purpose and target group of this study.

For many individuals like the Filipinos, who are motivated to work overseas or reside permanently in another country and culture due to financial reasons, migration as a transitory intervention becomes a major life event, and most potentially an enduring part of the environmental system in a new culture. Each day this phenomenon is multiplied across nations and cultures, thus making this dynamic transactional model of stress and coping pervasive and replicated globally.

The important factors, therefore, which need careful consideration in this study of challenges and coping of the older migrant population from non-western countries like the Philippines to western nations like Australia are the personal system (e.g. individual characteristics and resources such as personality traits, cognitive abilities, confidence, social competence, acculturation), the environmental system (e.g. social domain, physical domain, family, work, or resources), life events (e.g. physical and mental illness, occupational problems, racial discrimination, financial hardship, family problems, caregiving or grandparenting), intervention programs (e.g. economic, day care), the cultures of the country of origin and the host country, and the congruence between the personal and socio-environmental systems.

In studying the adaptation of older Filipino migrants in Australia, it is important to ascertain whether they possess the necessary personal coping resources (e.g. cognitive

abilities, motivation, values, beliefs, spiritual/religious, multicultural competence) and environmental resources (e.g. family, work, finance, housing, social support) that are particular to Filipinos in settling and adapting to ageing in the host country. This can be done by using Wong's resource-congruence model of adaptation for the Asian elderly and the adapted version (Dela Cruz, Padilla, & Agustin, 2000) of Marin and colleague's short acculturation scale for Hispanics (Marin et al., 1987) as the Filipino adaptation model shown in Figure 8.



*Figure 8.* Conceptual model of Filipino migrants' adaptation to stress

## **Chapter 5: Methodology**

Data from overseas-born Filipino women aged 40 years and over were used in the development and analysis of the survey. The women were divided into three groups according to their migration pattern: intermarried brides (B), intramarried spouses (S), and grandmothers (G).

The study was divided into two stages. Stage 1 was a qualitative interview of community leaders (CL) and Filipino women in Victoria. It was designed to elicit and identify common themes to be used in the national survey in Stage 2. Particular emphasis was given to experiences of Filipino women in primary caregiving roles.

Stage 2 was a national survey across five states in Australia (Victoria, New South Wales, Queensland, South Australia and Tasmania). The Stage 2 questionnaire was piloted in Victoria prior to national data collection. After preliminary analysis of the data and numerous presentations of progressive results at various conferences in Australia and overseas, a follow-up interview of four intermarried women was conducted at the end of the study. It was noted that the intercultural relationships between Filipino women and non-Filipino Australian men were still generating considerable interest both locally and abroad. In addition, the survey results appeared to defy the common categorisation and stereotyping of the Filipino brides. Hence, in order to gather a more meaningful picture of the intermarried brides' migration experience, it was decided by the researcher to conduct follow-up interviews with them. The questions were adapted from research on Filipino marriages in Canada (PWCBC, 2000). The women were approached by the researcher to participate in the follow-up interview. The women were chosen based on their expressed agreement to participate in an in-depth interview at the end of the survey.

## **Ethics Approval**

Ethics approval for this study was obtained from RMIT University (Appendix A). Ethics approval from FCCVI and its association members was not required as this umbrella organisation deemed ethics approval from RMIT as sufficient assurance of the study's ethical integrity.

## **Methodological Challenges in Conducting Research with Migrant Populations**

Recruitment of participants was initiated only after ethics approval. Recruitment procedures incorporated important ethical practices that must be followed when conducting research with migrant communities in order to be responsive to cultural concerns (Castro, Rios & Montoya, 2006). These practices included finding out about the community being investigated (Guerin & Guerin, 2007), and consulting with community leaders about how best to conduct the recruitment procedure (Trimble & Mohatt, 2006).

Engaging with community leaders in the research process is also in the spirit of promoting participatory social action and enables community leaders to act as gatekeepers to protect the rights of their community members (Castro et al., 2006). Additionally, when the research is supported by community leaders, participants are usually more willing to participate in research (Chin, Mio, & Iwamasa, 2006; Guerin & Guerin, 2007). Therefore, recruitment was preceded by meetings with the community leaders identified by the managers/president of each organisation. During these meetings, the study aims and research methodology were discussed, and copies of plain language statements, consent forms, and evidence of ethic approval documents were provided. Active recruitment of participants was initiated only after the researcher made amendments to the research methodology, as requested by community leaders. The recruitment strategies employed in each setting are described next.

## **Informed Consent and Associated Ethical Considerations**

When conducting research with migrant groups like elder migrants or refugees from Eastern societies or non-English-speaking countries, informed consent procedures are made more complex due to issues such as vulnerability, compromised autonomy, mistrust and the complexities of representation. Therefore, traditional western-informed consent procedures are often inadequate and inappropriate (MacKenzie, McDowell, & Pittaway, 2007). MacKenzie and colleagues (2007) proposed for an iterative model of consent in which ethical relationships are established between researcher and participants, so that consent procedures may be more responsive to participants' needs, concerns and values. According to researchers in cross-cultural studies (Bailes, Minas, & Klimidis, 2006; Barrett & Parker, 2003; MacKenzie et al., 2007) iterative models of consent begin when researchers consult with community leaders, representative bodies, or with non-government organisations (NGOs) where appropriate, about how best to proceed on matters of informed consent. These consultations establish the research as a partnership, and encourage the migrant community to play an active role in setting the research agenda. Hence, this process shows respect for the values and concerns of the participants. It also helps to build trust and to avert misunderstanding (MacKenzie et al., 2007).

Therefore, the consent process for this study began by meetings held with consenting organisations and the community leaders nominated by these organisations. At these meetings, the researcher described the study's aims and methodology, and provided copies of consent forms (Appendix B), the plain language statement (PLS, Appendices C & D), and a list of the proposed semi-structured focus group questions (Appendices E, F, & G). The researcher made a verbal request for the community leaders to inform the researcher should any aspect of the proposed study or consent procedures appear contrary to cultural norms.

The researcher also asked for any other feedback or input regarding the study proposal, and finally, asked permission for the research to proceed.

On the advice of all community leaders, consent for participation was obtained either verbally or in written format. Barrett and Parker (2003) stated that the notion of a written contract does not always have the same purchase in other cultures as it does in western cultures. Once the informed consent strategy was finalised, the target sample was approached and the recruitment phase was carried out between 2005 and 2006. The prolonged recruitment phase at these various community locations was essential to develop rapport and give participants time to reflect on their participation. During recruitment, the researcher always stressed that participation was voluntary, and that there would be no adverse consequences for refusing to participate in the study. The researcher and the community leaders also made themselves available to answer any questions or concerns that potential participants may have had.

### **Stage 1 Qualitative Interviews in the State of Victoria**

#### **Stage 1 Participants**

##### **Sampling**

The current study used a non-probabilistic, purposive sampling approach to recruit participants. According to the available literature, it is important to select participants who are able to provide insight into the topic being researched in conducting research using focus groups (Asbury, 1995; Halcomb, Gholizadeh, DiGiacomo, Phillips, & Davidson, 2007).

##### **Community leaders in Stage 1.**

Stage 1 consisted of 30 community leaders (CL) representing 17 organisations in Victoria, Australia. For the purposes of this study, the term community leaders refers to officers of Filipino community associations, paid staff, and volunteers providing services to the Filipino community either in mainstream or ethno-specific organisations. Within the



community leaders, there were 20 females and 10 males representing a total sample of 17 organisations in both urban and regional areas of Victoria. The organisations were grouped into four categories: Filipino-Urban ( $n = 5$ ); Filipino-Regional ( $n = 4$ ); Mainstream-Urban ( $n = 2$ ); and Specialist Services ( $n = 6$ ). Among the community leaders, 46.7% were in management, 43.3% in direct service provision, and 10.0% were volunteers.

### **Filipino women in Victoria in Stage 1.**

A total sample of 169 overseas-born Filipino men ( $n = 41$ ) and women ( $n = 128$ ) in Victoria served as informants in this stage of the study but only data from women were included in Stage 1. The women's age ranged from 40 to 88 years ( $M = 64.48$ ,  $SD = 12.84$ ), with 84 brides and 44 grandmothers ( $M = 78.00$  years). Nearly 76% of the women were residing in urban areas, while 24% were residing in regional or remote/rural areas of Australia. Within the group of brides, participants were categorised as intermarried brides (married to non-Filipino men) ( $n = 50$ , mean age = 57.04 years) or intramarried spouses (married to Filipino men) ( $n = 34$ , mean age = 57.94 years). In the sample of 128 women, 57 were in a kinship primary caregiving role.

### **Materials for Stage 1**

Separate lists of proposed semi-structured questions for community leaders (Appendix E) and Filipino women in Victoria were designed in consultation with a senior community leader with specialisation in aged care, as well as review of literature on acculturation, stress and coping, mental health and service utilisation of ageing migrant communities. Each package included a plain language statement (PLS, Appendices C & D) and a consent form (Appendix B). The list for the Filipino women was available in both English (Appendix F) and Pilipino (Appendix G).

### **Questionnaire for community leaders in Stage 1.**

A separate semi-structured questionnaire for leaders (CL) and an open-ended interview questionnaire for Filipino women (FW) in Victoria were used in Stage 1.

A one-page open-ended questionnaire was provided for each community leader to complete before the start of the interview. This questionnaire asked the leaders about their gender and ethnicity, information about the organisation (e.g. government or non-government) that the community leader represented, their position in this organisation (e.g. Chairperson, Project Officer, Outreach Worker), the type of services provided by the organisation (e.g. settlement, aged care, carer support, medical/health, education), and perceptions about enablers and barriers to accessing these services by CALD communities, particularly the Filipino community. The leaders were then asked about the main presenting concerns of clients of the services and what additional community support might be required by older Filipino participants. The interview questions elaborated on four areas: (1) presenting concerns of Filipino clients, (2) existing services older Filipinos access in their organisation, (3) additional support they think older Filipino clients require, and (4) what makes it easy or hard for the community leaders and their organisations to provide services to CALD groups, particularly the Filipino community.

### **Questionnaire for Filipino women in Victoria in Stage 1.**

The package for the Filipino women (FW) in Victoria included demographic details such as sex, date of birth, education, religion, marital/relationship status, employment status, year of migration and place of residence. FW completed the demographic details before the start of focus group. The questions for the Stage 1 focus groups with FWs were: (1) What were your expectations of Australia prior to migrating? Were they met? (2) How would you describe your first years of adjustment in Australia? (3) What were the good things about coming to Australia? and (4) What were the difficulties? How did you manage them?

Additional questions addressed whether a participant had a primary kinship caregiving role. The questions for caregivers included questions on the positive (rewards) and negative (challenges) aspects of primary caregiving. Examples of questions were (1) Is the caree your Spouse, Grandchild, Parent or Others? (2) Are you still caring for them? (3) How do you manage as a caregiver? (4) What are the circumstances that led you to becoming the carer for your Spouse/Grandchild/Parent? (5) What are the challenges and reward of your role? (6) What type of social services do you and your spouse/grandchild/parent need? (7) Which services do you access? (8) Do you find their service provision adequately meeting your needs and needs of your spouse/grandchild/parent? (9) What do you prefer health and social service agencies provide so that they can be more responsive to the needs of families in similar situations?

### **Procedure for Stage 1**

#### **Design for Stage 1**

Qualitative data was collected using focus group interviews. Qualitative methods are appropriate when exploring a phenomenon, or when little is known about a group's attitude on an issue (Green & Thorogood, 2009). Focus groups are a type of group discussion that is focused around a specific issue and utilises group interactions to stimulate thinking and verbal contributions for the collection of data (Asbury, 1995; Kitzinger, 1994). They are particularly useful in obtaining insight into a group's opinion, attitude, vocabulary and reasoning about an issue (Ekblad & Baarnhielm, 2002) and for engaging CALD populations because many CALD societies have strong oral cultural traditions (Halcomb et al., 2007; Huer & Saenz, 2003; Owen, 2001; Saint-Germain, Bassford, & Montano, 1993).

Given limited financial resources, it was initially deemed practical to conduct metropolitan and regional focus groups for this study. However, due to requests from community leaders of other Filipino groups in both metropolitan and rural areas in Victoria

and the need of the industry partner for data for an aged care funding application, the focus group interviews were expanded with the assistance of the senior community leader and two community volunteers and financial support from the researcher's RMIT research fund.

### **Data Collection for Stage 1**

The study involved urban and regional areas of Victoria, Australia. Purposive sampling was used to recruit participants in 2005–2006 for Stage 1. The researcher conducted group interviews of overseas-born Filipino women in Victoria in Stage 1. Interviews were conducted during Filipino association meetings at community centres/seniors halls, or at participants' homes. The Filipino women chose interviews in either English or Pilipino/Tagalog languages or a combination of Pilipino/Tagalog and English.

#### **Focus group procedure.**

The location, date and time of the focus groups were set after negotiations between the researcher, the participating organisations and their respective community leaders. The focus groups were conducted on the premises of the participating peak organisations in urban and regional areas, which was ideal because participants were familiar with the venues and could easily access them. Krueger and Casey (2000) suggested that the ideal number of participants falls between six and eight because it allows for a variety of perspectives to be obtained without the focus groups becoming unmanageable. Therefore, the number of focus groups was scheduled based on the number of participants who registered their interest in participating in the focus groups.

At the suggestion of senior community leaders, food and refreshments were also made available. The physical environment of the interview room was arranged so that participants were seated in a circle, with a table in the middle where the food and refreshments were placed. Two volunteers, who acted as research assistants, were in attendance at each focus

group. To encourage participation and in appreciation of the cultural mores of the participants, the interviews were documented but not digitally recorded.

Before the focus groups began, the research assistants were briefed about the study's aims and were given a copy of the PLS to read. As participants arrived, they were welcomed and ushered to their seat. When all participants were seated, the researcher described the reason for the gathering, explained how focus groups generally work, and summarised the information in the PLS, ensuring that participants were aware of their rights, and had all the information required to make an informed decision about their participation. The participants were reminded that the discussion would be documented by the research group. They were also instructed not to disclose family names so as to preserve their anonymity in the documentation. The researcher also advised the participants that personal information disclosed during the discussions should not be repeated outside of the group. Once all queries had been addressed, and verbal consent for participation had been obtained, the researcher officially began the focus group.

Each focus group ran for approximately 90 minutes. They were moderated by the researcher, who also made field notes during and after the focus groups. Field notes can provide auxiliary information, about such matters as non-verbal gestures, the group dynamic and interactions between participants that cannot be derived from transcripts (Krueger & Casey, 2000). Participants were not paid for their involvement. However, the researcher sent a thankyou card to each organisation and requested that her gratitude be communicated to all participants for their contribution. Focus groups were conducted in metropolitan areas (Maribyrnong, Sunshine, Dandenong and St Albans) and regional areas (Geelong, Ballarat, Bendigo, Shepparton and Gippsland).

## **Stage 2 National Survey**

### **Ethics Approval for Stage 2**

The College Human Ethics Advisory Network of the RMIT University Human Research Ethics Committee approved the present study (Appendix A).

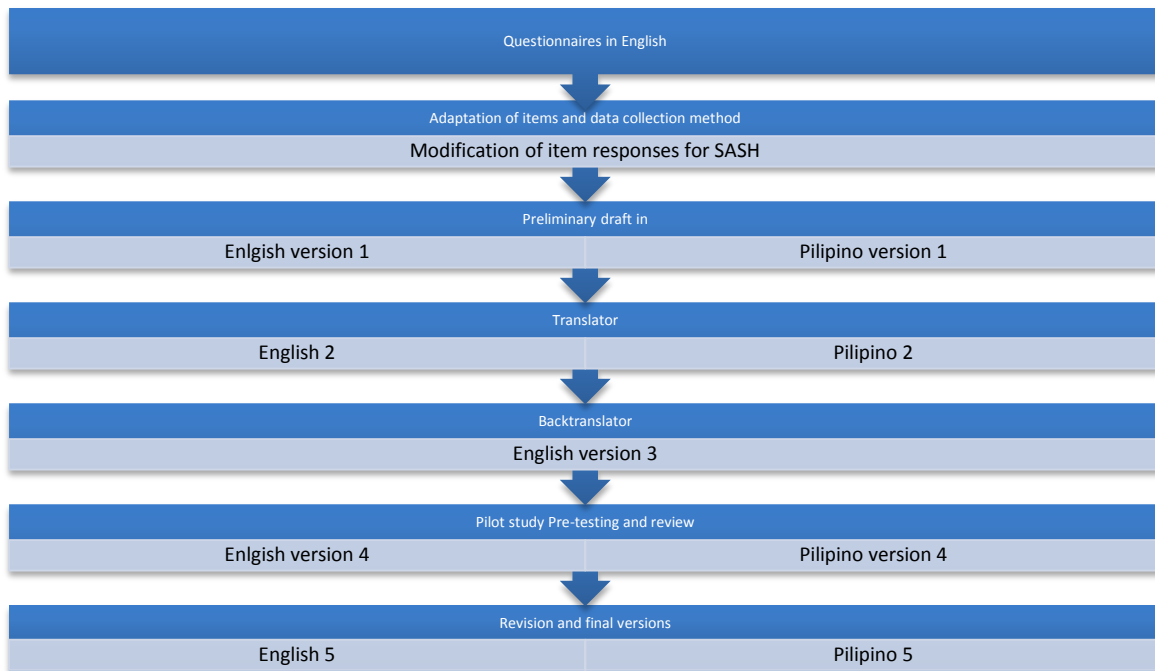
### **Recruitment of Participants and Associated Ethical Considerations for Stage 2**

As with Stage 1 of the research project, recruitment of participants was initiated only after ethics approval from relevant groups had been obtained. Recruitment procedures for migrant groups that were useful in Stage 1 were incorporated in Stage 2 of the project (Guerin & Guerin, 2007). Community leaders were again consulted about how best to conduct the recruitment procedure (Owen, 2001; Trimble & Mohatt, 2006) in order to maintain being responsive to cultural concerns (Castro et al., 2006; Enriquez, 1993). As observed in Stage 1 and consistent with available literature (Chin et al., 2006; Guerin & Guerin, 2007), participants are usually more willing to participate in research when encouraged by their community leaders. Recruitment was again preceded by meetings with the community leaders identified by the senior community leader. During these meetings, the study aims and research methodology were discussed, and copies of PLSs, consent forms, and evidence of ethic approval documents were provided.

### **Pilot Study of the Survey Instrument for Stage 2**

As shown in Figure 9, with the assistance of a qualified interpreter/translator, the questionnaires were translated from English to Pilipino, then to ensure the semantic equivalence of the Pilipino translation, the questionnaires were translated back to English before being piloted to a group of Filipinos. As discussed in Chapter 3, because Philippine-born migrants in Australia came from various regional cultural and linguistic/dialect groups of the Philippine archipelago, the Philippine national language Pilipino would be used in this study instead of Tagalog, which although widely used, may be considered by some

community groups as exclusive, representing only a regional dialect that is closest to the national language Pilipino.



*Figure 9.* Pilot study of the survey instrument for Stage 2  
Adapted from Dela Cruz et al., (2000).

A pilot study involving eight individuals was undertaken to assess the feasibility, readability and cultural relevance of the questionnaires. Three Filipino seniors, two aged care workers and three community leaders participated in piloting both English and Pilipino versions of the questionnaire package.

First, the respondents were instructed to complete the questionnaire package in English and to provide comments on the content and presentation of the package. On completion of the questionnaire packages, the respondents were asked to comment first, on time taken to complete the questionnaire package; second, on the length of the entire questionnaire package; and third, on clarity or ambiguity, and cultural relevance of the items. After completing the questionnaire package in English, they were asked to complete the Pilipino version and as with the previous package, provide comments on content and presentation.

Several respondents commented on the length of the questionnaire package and the considerable time taken to complete it. Several respondents also reported that like most ethnic groups, elderly Filipinos are often reluctant and suspicious of completing pen and paper measures and recommended that the questionnaire package be shortened. Thus changes were made to reduce the length of the questionnaire package. The scales on general health and caregiver burden were removed and the shorter version of the coping scale was adopted.

The respondents also emphasised that some elderly participants would need assistance completing the questionnaire from family or workers due to a decline in eyesight or motor coordination. It was therefore recommended that in addition to distributing individual questionnaire packages to interested individuals, packages should be distributed to Filipinos at various clubs and centres, and that the questionnaire items be read to elderly participants either individually or in a small group setting.

A qualified interpreter in the Pilipino/Tagalog languages rechecked the revised questionnaire packages. Acknowledging the variety of languages/dialects within the Filipino culture, expert review by the qualified bilingual interpreter confirmed the balance between the colloquial and formal language of the Pilipino version.

The respondents recommended that the qualifying age for participation in the study be lowered from 55 to 45 years as they believed that the survey would be relevant to many women they knew in the community whose experience would contribute to the depth of the study. This resulted in lowering the entry age to 45 years, which was subsequently lowered again to 40 years as the data collection progressed. This consideration only emerged once the data collection had begun because of the following reasons. First, the Filipino concept of ageing is coming to be more clearly defined not only by chronological age but also by roles (grandparents). If this study were to contribute to the linkage partner's strategic planning for the projected ageing of this gender-imbalanced Filipino community in 20 years, it seemed



imperative that younger adults be included in the current study. Second, younger members of the community expressed interest in the study and asked to participate. Consequently, the entry age of participation was lowered to 40 years of age. Filipino men also expressed interest in the study and participated. However, the male experience was not part of the parameters of the current study, so data from men are not included in this report.

## **Participants in Stage 2**

Stage 2 consisted of 282 overseas-born Filipino women from five Australian states and territories. The participants were recruited between 2005 and 2007.

The sample ranged in ages from 40 to 89 years ( $M = 57.66$ ,  $SD = 12.53$ ), with 139 brides (mean age = 52.87,  $SD = 11.98$ ), 91 spouses (mean age = 53.40,  $SD = 9.14$ ) and 52 grandmothers (mean age = 77.90,  $SD = 6.22$ ). Seventy one per cent of participants were residing in urban areas, while 29% were residing in regional or remote/rural areas of Australia. A third of the total sample were in a primary caregiving role, with ages ranging from 42 to years 89 years. A description of the participants' age, marital status, education level, occupation, place of residency and caregiving role for each stage is presented in Tables 11-12.

## **Materials for Stage 2**

For Stage 2, the same package was administered to the three groups of Filipino women (Brides, Spouses, Grandmothers). The survey package (PLS, Appendix H; English, Appendix I; Pilipino, Appendix J) retained similar demographic questions such as: sex, date of birth, education, religion, relationship status, employment status, year of migration and place of residence. Each participant's partner's nationality, education and age were gathered in Stage 2. The questions on migration, settlement and caregiving experiences were designed in a closed format and included closed questions on the concept of ageing, a series of scales on acculturation, mental health, coping and social support.

The battery of measures designed to gauge conceptually related dimensions of settlement, acculturation, ageing, caregiving, mental health, coping, and social support in the Stage 2 national survey comprised the following sections:

1. Demographic questionnaire
2. Filipino Experience Questionnaire (FEQ)
3. Acculturation: 12 items
4. Mental health: 21 items
5. Coping: 28 items
6. Social Support: 23 items

#### **Demographic questionnaire.**

A demographic questionnaire was designed to identify personal characteristics of the participants, including year of arrival and visa category, age, sex, highest education attained, religion, marital status, number of children in Australia and those in the Philippines, reason for migration, living arrangements, sources of income, care and support.

#### **Filipino experience questionnaire.**

The Filipino Experience Questionnaire (FEQ) was a demographics questionnaire developed on the basis of the results of Stage 1 and a review of literature. The FEQ comprised closed format questions with numerical rating scales. Inclusion of middle, non-committal answers like “Not applicable” and “Other” were considered in the design of the questionnaire. The FEQ explored issues applicable to the older Filipino population, specifically, experiences during the initial settlement period, and their subsequent integration into the community, their use of health information and services, preferred support services when aged, preferred cultural background of aged care service providers, social ties, and the concept of ageing. Additional questions for participants who were primary carers explored

issues on their caregiving experience and access to psychological and social resources for support.

### **Acculturation.**

The Short Acculturation Scale for Hispanics (SASH; Marin et al., 1987) was adapted to create the Short Acculturation Scale for Filipino Australians (SASFA). The SASH self-administered acculturation scale includes 12 items that relate to three factors: language use (5 items measuring language use and preference as work, home and with friends), media (3 items measuring media language use and preference), and ethnic relations (4 items measuring ethnic preference of individuals in social relations).

Responses use a five-point Likert scale. For the first eight items that ask about language and media use and preference, response options are 1 = *only Spanish*, 2 = *more Spanish than English*, 3 = *both equally*, 4 = *more English than Spanish*, and 5 = *only English*. In adapting the scale for use in this study “Pilipino/Dialect” replaced “Spanish” in the choice of responses. For the four items about ethnic preference in social relations, the response choices are 1 = *all Latinos/Hispanics*, 2 = *more Latinos/Hispanics than Americans*, 3 = *about half and half*, 4 = *more Americans than Latinos/Hispanics*, and 5 = *all Americans*. In adapting the scale for use in this study, “Latinos/Hispanics” was replaced with “Filipinos”, and “Americans” was replaced with “Australians”. Scores ranged from 12 to 60 with high scores representing a higher level of identification with the host culture.

The SASH measure was chosen for several reasons. First, the SASH is widely used in cross-cultural research on Hispanics, Anglo-Americans and Asians. Second, it has a reliability Cronbach’s alpha = .92, with a reliability Cronbach’s alpha = .86 for the sample in the current study. Third, this measure was adapted in a Filipino-American study by Dela Cruz and colleagues (2000). They found overall Cronbach’s alpha coefficient for internal consistency was .85 and a factor analysis with varimax rotation yielded the same three

factors: language use, media and ethnic relations. Stepwise multiple regression revealed ethnic identification as the primary predictor of the level of acculturation. The brevity of the measure allowed the researcher to quickly and reliably identify Filipino migrants who are low or high in acculturation. It does not include socio-demographic variables like length of residence and age on arrival as part of the scale, thus these variables can be used as correlates of acculturation. Filipino people share a Hispanic background and common historical cultural roots as a result of more than three centuries of Spanish colonisation of the Philippines. Marin et al. (1987) noted that as a whole, Filipinos are like Hispanic Americans; they remain focused on the value of the family, which includes focus on the nuclear and extended kinship group. In contrast, as argued by Leong and Chou (1994), conceptually the SL-ASIA is linked to the Chinese American Identity Model of Sue and Sue (1973).

### **Mental health.**

The Depression Anxiety Stress Scales -21 (DASS21; Lovibond & Lovibond, 1995) is a 21-item shortened version of the 42-item DASS scale. The DASS assesses the current state or change in state on three dimensions of depression, anxiety and stress. Examples of items are “I found it hard to wind down” and “I tended to overreact to situations”. Participants are required to respond to each item on a four-point Likert type scale ranging from “Did not apply to me at all” to “Applied to me very much or most of the time”. Total sum scores range from 0 to 160, with higher scores indicating increased levels of depressive, anxiety, or stress symptoms. The DASS has been well validated and normed in measuring risk for depression, anxiety and stress in Australian population and in an Asian sample (Musa, Fadzil & Zain, 2007; Norton, 2007). The DASS has convergent validity with the Beck Depression Inventory and Beck Anxiety Inventory of .74 and .81 respectively (Crawford & Henry, 2003), and a Cronbach’s alpha between .86 and .90 in older adults (Gloster et al., 2008). The Cronbach’s alpha = .93 for the sample in the current study.

### **Coping.**

The Brief-COPE (Carver, 1997) was chosen because of its value in health-related research and its brevity. It is a 28-item version of the 60-item COPE (Carver et al., 1989) designed to measure coping responses known to be relevant to effective and ineffective coping. Items are presented as self-predicated responses to stress such as “I get upset and let my emotions out” and “I laugh about the situation”. The participant is required to respond to each item on a four-point Likert type scale ranging from “I usually don’t do this at all” to “I usually do this a lot”, with higher scores indicating greater use of that coping resource. For this study, the Brief-COPE was used to measure 14 conceptually differentiable coping reactions including those that are distinct to Filipinos in general like Religion and Humour (D’Mello & Esmaguél, 1990; San Jose, 1995). The Brief-COPE has demonstrated internal reliability between Cronbach alpha = .72-.84 (Cooper, Katona, Orrell, & Livingston, 2008). The Cronbach’s alpha = .89 for the sample in the current study.

### **Social support.**

The Social Support Appraisals Scale (SS-A) (Vaux et al., 1986) was used to measure subjective appraisals of support resources and interactions identified in Wong and Ujimoto’s resource-congruence model of adaptation. This 23-item questionnaire asks participants to indicate on a four-point Likert scale ranging from “1 = Strongly disagree” to “4 = Strongly agree” how much they believe that they were loved by, esteemed by, and involved with family members, friends and others. The scores are typically computed separately for the three subscales: support by family members (8 items), support by friends (7 items), and support by others (8 items). Low scores equal high support. The SS-A has demonstrated internal reliability of Cronbach’s alpha = .81-.90. The Cronbach’s alpha = .90 for the sample in the current study.

## **Procedure for Stage 2**

### **Data Collection for Stage 2**

The study involved five states of Australia (Victoria, New South Wales, Queensland, South Australia and Tasmania). Purposive sampling was used to recruit participants in 2006–2007 for Stage 2.

The methodology applied in this research project was designed to address the principal barriers to research with participants whose first language was other than English. Such barriers included limited access to the ethnic community, difficulties with recruitment of participants, geographical dispersion and transport issues, access to interpreters, and cost and lack of suitable culture-free psychological tests. To address these barriers, the researcher employed various data collection methods appropriate to the ethnic group targeted in this research project.

The researcher is from the same linguistic and cultural background as the overseas-born Filipino informants and conducted the research following indigenous psychology for Filipinos (Enriquez, 1981, 1989, 1993; Pe-Pua, 1995). “*Pakapa-kapa*” which is akin to probing or searching into a mass of social and cultural data to be able to maintain order, meaning, and directions for research (Torres, 1995) was used particularly in Stage 1. Through this procedure, the themes, concepts and variables were identified for Stage 2 of the study. Throughout the duration of the study, “*patanung-tanung*” (asking around) occurred whereby the researcher interacted with Filipino women in their natural habitat like meeting room or home (Gonzales, 1998) and established and maintained empathy where culturally appropriate in conducting research on Filipino psychology. It was aimed that this integration facilitated a reasonable match between the psychological phenomena and the description and interpretation of the phenomena pertaining to the Filipino brides, spouses and grandmothers.

A research reference group comprising two academic supervisors, a Linkage consultant, and a PhD student was established and met periodically at the early stage of the project to oversee the initial rollout of the project. Trained aged care workers assisted the main researcher in interviewing participants from the ethno-specific aged day care centre. The researcher resourced community media, leaders and various groups, like social clubs and church associations; travelled to regional areas; translated and back-translated the questionnaire package; and then piloted to several informants.

Snowballing was also used because it has been proven effective in finding and recruiting groups that are not accessible to researchers through other sampling strategies (Xenos, 2000). The snowballing effect was used to recruit overseas-born Filipino women aged 40 and older living in both urban and regional or remote areas of Australia. Using this method, participants or informants used their social networks to refer the researcher to other people who could be potential participants in the study. The project was also advertised in the ethnic radio, newspaper and at various Filipino groups' meetings and cultural gatherings. The researcher advertised the project through ethnic radio interviews followed by a newspaper article printed in English in a Filipino newspaper. The article provided a description of the research project, and contact details for interested readers who wanted to participate in the project. The article noted that participation was voluntary and anonymous. The researcher attended various Filipino group meetings and cultural gatherings including the annual Philippine Fiesta and bi-annual state conference of Filipino Community Council of Victoria (FCCV) and national convention of Federation of Filipino Community Councils in Australia (FECCA) to promote the project and actively involve community leaders in inviting their members and wider social networks to participate in the various stages of the studies. The researcher travelled to metropolitan Melbourne, regional Victoria and to South Australia during the FECCA conference.

Most participants were referred to the researcher by Filipino community leaders, aged care service providers, and some by the wider informal social network. The consultant gave the researcher a list of Filipino associations in metropolitan Melbourne and regional areas that the researcher contacted to invite female association members to participate in this study. The researcher sent the invitation to these groups to participate in the study, then followed up with a telephone call to schedule a visit. The location, date and time of the survey was set after negotiations between the researcher, the participants and their respective community leaders.

The researcher initially attended the meetings of Filipino associations and met community leaders in both metropolitan and regional areas of Victoria to introduce the research project. Following this, association leaders in metropolitan Melbourne and regional Victoria arranged group meetings for the researcher to conduct individual interviews. Individual interviews were conducted at the ethno-specific centre and Senior Citizen Centres in metropolitan and regional areas in Victoria, Australia. Participants had a choice of either the English or Pilipino version of the questionnaire package. The interviews were conducted for up to one-hour duration with a short break for older participants. Officers of some groups provided some ethnic food for the group, some proudly endorsing delicacies specially made by certain members in the community. Most officers or their membership in the regional areas also offered their family home as accommodation for the researcher.

The researcher gave a brief presentation about the nature of the study, why such study is needed, for example, for exploratory reasons to understand the challenges the Filipino community is facing as it rapidly approaches ageing in the host country and to look at service provision and utilisation that are pertinent to this community. The researcher emphasised some of the reasons behind this research project, for example, the different migration patterns of the Filipino women, geographical dispersion of these population, and the



acknowledgement of difficulties providing culturally, linguistically and appropriate services to older migrants. All participants were informed that the study was voluntary, and they would give implied consent by taking part in the interview. Confidentiality would be maintained and all possible identifiers of the participants would be avoided. Participants were informed on how to contact the researcher if they had any queries following their participation. The participants were invited to ask questions at the end of the presentation.

During data collection for Stage 2, a handful of younger adults requested an electronic version so an alternative electronic copy was made available to the participants who preferred to participate via electronic medium. Survey Monkey was not considered in the first instance because of the varying generational age and computer skills of the target sample. The completed questionnaires were returned to the researcher in sealed envelopes or by email. To ensure confidentiality each paper was coded and the identifying information locked away.

### **The National Survey for Stage 2**

All participants were of Filipino background residing in urban and non-urban areas of the five states and territories of Australia (namely Victoria, NSW, Queensland, South Australia and Tasmania). Most participants were recruited through Filipino aged care services, Filipino seniors clubs, state and national peak bodies for Filipino migrants in Australia (e.g. FCCVI and FECCA), various Filipino interest groups and church groups. A Snowball recruitment method was used to access older people who were not members of any Filipino associations, particularly those in regional or rural areas.

For Stage 2, the aged care workers who participated in the pilot study either gave interested individuals a copy of the questionnaire package and were asked to send them back to the primary researcher, or negotiated a suitable place and time when interested parties could meet to complete the survey individually with the primary researcher present. A small number of individuals requested an electronic version of the questionnaire package. An

electronic Word document version was devised and sent to the interested parties who were encouraged to send them back by email or print out and return by mail.

### *Exclusion criteria*

Overall, 470 overseas-born Filipinos who were permanent residents in Australia participated in the study including 55 men. However, for the purpose of this current research, only responses from Filipino women were analysed and reported in this study. In addition, five Filipino women who were non-residents in Australia, or failed to complete a signed consent form, or were below the target age of 40 at the time of recruitment, were excluded in the data analysis. There were no age or gender criteria for the community leaders to participate in the study. The total number of participants included in this study was 17 community leaders and 410 Filipino women aged 40 years and older.

### **Qualitative data for Stage 2.**

Follow-up questions on the relationships of intermarried women were developed to gather more qualitative information to assist with interpretation and understanding of the gendered migration for marriage phenomena. The follow-up open-ended questions for the eight intermarried women focused on each couple's meeting, the woman's ideas about marriage, her relationship with her husband, family and other Filipinos, income and general health (Appendix K). Examples of questions are "What made you decide to marry a foreigner/Australian?" "How did your family react to your relationship to a foreigner?" "How is your relationship with your husband?" "Did you tell your parents in the Philippines about your problems (in Australia)?" and "How is your general health?" The women were interviewed individually at their place of residence. The summary of the interviews with eight Filipino women were presented in Chapter 7.

## **Chapter 6: Stage 1: Focus Groups with Community Leaders and Filipino Women in Victoria**

Stage 1 comprised of focus groups designed to (a) identify the primary concerns of middle age and older Filipino migrant women in the community and (b) the service utilization of aged-care services as perceived by both these Filipino women and community leaders from both mainstream and ethno-specific organizations in Victoria.

Anecdotal evidence and past research indicate that Filipino brides/spouses are currently balancing triple roles as parents, carers to older parents, spouses and grandchildren, and breadwinners for the family while concurrently approaching old age (D'Mello & Esmaguél, 1990; San Jose, 1995). Anecdotally, community leaders and health care professionals within the Filipino community frequently refer to the stresses of older Filipino women who, while engaged in caregiving of a number of family members, also have very little if any family support from either their sponsoring family or from members of the Australian family they have married into. However, little research has focused on the stressors and coping of these women and the impact of these stressors on their mental health. Given the important role of community leaders as service providers within the Filipino community and their involvement with a number of Filipino families, and in particular elderly women, it was decided to conduct focus groups with both the women themselves as well as the community leaders. Thus, Stage 1 of the research involved the undertaking of qualitative interviews with both community leaders (CL) and overseas-born Filipino women (FW) in Victoria.

The questions included in the Stage 1 focus group interviews were based on the review of literature on gendered migration and the challenges, stressors, and coping resources that women are confronted with in their daily roles as caregivers and breadwinners. Overall, a total of 30 CLs and 128 overseas-born FW in Victoria were recruited for the Stage 1 focus

groups. The data obtained in these focus groups was then used to guide the development of the Stage 2 national quantitative survey examining the challenges and mental health of Filipino women across Australia. This chapter reports on the results obtained from both the CLs and FWs. Data from the Stage 1 focus groups are presented separately for the older FW and separately for the CLs within this chapter. This is followed by a short summary highlighting key issues of concern that were then used in the development of the quantitative survey implemented in Stage 2 with the wider Australian Filipino community.

### **Group 1: Community Leaders**

#### **Community Leaders (CLs)**

For the purposes of this study, the term community leaders refers to staff members employed within Filipino community associations as well as volunteers providing services to the Filipino community either in the mainstream or ethno-specific. Community leaders from the Filipino ethno-specific and mainstream support services were approached by the researcher and invited to attend a focus group organized by the researcher. At this focus group meeting, CLs were invited to complete semi-structured interview questions that were designed to elicit information about their perceptions of the challenges confronted by older Filipino women as well as their perceptions of the service utilization of these women. Further discussion then ensued regarding each of the questions on the questionnaire. This information was recorded by the researcher, and a thematic analysis conducted. This is presented in the Results section of this chapter.

### **Method**

#### **Participants**

The sample comprised of 30 CLs from mainstream and ethno-specific organizations within urban and regional areas of Victoria. Demographic information regarding these CLs is presented in the Results section.

## Measures

The questions included in the semi-structured interview were based on a review of the existing literature regarding the concerns of ageing communities in general, as well as consultation with a senior community leader with specialization in Filipino aged care. The questionnaire for the CLs included a plain language statement, a consent form, and a one-page open-ended questionnaire. The open-ended questionnaire asked the CLs about their gender and ethnicity, information about their organization (e.g. government or non-government), their position in this organization (e.g. Chairperson, Project Officer, Outreach Worker), the type of services provided by their organization (e.g. Settlement, Aged Care, Carer support, Medical/Health, Education), and their perceptions regarding the challenges, including enablers and barriers, to the utilization of services by elderly Filipino women. The questions comprising the Stage 1 focus groups with CLs were: (1) What are the presenting concerns of Filipino clients? (2) What existing services do older Filipinos access in your organization? (3) What additional support do you think they require? and (4) What are some of the enablers and barriers in your organization in providing services to the older Filipino females?

## Procedure

A senior CL was recruited with the recruitment of other CLs. This strategy has been recommended by past researchers when conducting focus groups on cross cultural topics. With the assistance of the senior community leader, other community leaders were invited to take part in the research project. The senior CL gave the researcher a list of mainstream services in metropolitan and regional areas that the researcher then contacted to invite CLs to participate in this study. Following a written invitation, the researcher then contacted each organization to schedule a time to conduct a meeting with interested CLs within each organization.

CLs who expressed an interest in participating in the project were given a brief description of the nature of the study, the importance of the research, and the requirements for participants. All CLs were informed that the study was voluntary, and they would give implied consent by agreeing to take part in the interview. All leaders were informed that their names were not requested, that confidentiality would be maintained, and that all possible identifiers would be avoided. The leaders were informed on how to contact the researcher if they had any queries following their participation. They were invited to ask questions at the end of the presentation. Literature has indicated that when the research is supported by community leaders, participants are usually more willing to participate in research (Chin et al., 2006; Guerin & Guerin, 2007). In addition, the community leaders act as gatekeepers to protect the rights and participation of their community members (Castro et al., 2006).

### **Data Analysis**

Thematic analysis was used to analyse the data collected from the CLs. Using an inductive approach, data analysis focused on eliciting themes centered around the presenting issues for ageing female Filipinos as perceived by the CLs, the use of community services, and what promote or hinder access to services by older Filipino women. Using qualitative and quantitative methodology is recommended when conducted cross cultural research (Mio et al., 2006). Data were categorised into recurrent or common themes by looking at each segment of text within a transcript and asking “what is this text *about*?” and “how is it *similar* and/or *dissimilar* to other segments of text?” In this way, each segment of text was inductively coded into succinct themes that summarise the key elements within the respondents’ accounts (Green & Thorogood, 2009). The transparency of the analysis is exemplified by presenting extensive verbatim quotes in the result section of the current study.

The verbatim quotes in the result section of the current study supported the analysis (Yardley, 2000).

## Results

### Organisations

The 30 CLs were from 17 different associations and services that represented four types of organizations grouped as Filipino-Urban (n=5), Filipino-Regional (n=4), Mainstream-Urban (n=2), and Specialist services (n=6). The organizations were divided into these four groups to represent the services being provided by these organizations and the access to these services by the Filipino women in urban and regional areas. Most (15 of the 17) organizations were non-government; the remaining two were Local Council government organizations. Details of these organizations are given in Table 4.

Table 4

#### *Organisations Based on Service Types*

	Filipino- Urban n=5	Filipino-Regional n=4	Mainstream- Urban n=2	Specialist Services n=6
3ZZZ Radio	0	0	0	1
Aus-Fil Association of Geelong	0	1	0	0
Aus-Fil Club NSI	0	1	0	1
CCV	0	0	0	1
Centre for Pilipino Concerns	3	0	0	1
Australia-Vic				
Domestic Violence Outreach Service	0	0	0	1
ECS	0	1	0	0
FASocial Club of Loddon	0	2	0	0
Campaspe				
FCCouncil of Vic	8	0	0	0
FCWelfare Sservices	1	0	0	0
Medical Clinic	0	0	0	3
Hume City Council	0	0	1	0
LTCHS	0	0	0	1
MnMService	0	0	0	1
Moreland City Council	0	0	1	1
Phil Foundation	1	0	0	0
Phil Language Sch	1	0	0	0
SBS Radio	0	0	0	1

The Filipino-urban groups were represented by leaders from organizations including the Filipino Community Council of Victoria Inc. (FCCVI), the Centre for Pilipino Concerns

in Australia-Victoria (CPCA), and the Filipino Community Welfare Services (FCWS). The Filipino-regional group comprised of CLs from Filipino-specific organisations in Geelong, Bendigo, and Gippsland. The Local Council group comprised of CLs from Moreland and Hume City Councils. The Specialist services comprised of CLs from medical, media and a language school. The Specialist groups were from urban and regional areas in Victoria.

### Services Provided by Organizations

Table 5

#### *Services Provided By Organisations*

	Filipino- Urban	Filipino- Regional	Mainstrea mUrban	Specialis t Services	Total services
General Practitioner				2	2
Allied health	1			2	3
Access/Advocacy	4	4		4	12
Carer Support	2	1	1	1	5
Carer Info & Training	2	1		3	6
Settlement services	3	3		2	8
Brokerage	1				1
Transport	2	1	1	1	5
Private service	1			2	3
Residential accommodation					0
Residential respite	1				1
Aged care	2		2	1	5
Disability service	1	1	2	1	5
Informal support	4	2		2	8
Food service	1		2		3
Equipment					0
Hospital					0
Home nursing					0
Home maintenance			1		1
Home help	1		2		3
In home respite	2		2		4
Personal care	1		2		3
Recreation	2	3	1	1	7
Neighbour aid	1				1
Media				1	1
Language education	1				1
Day care	2		1	1	4
Telelink	1				1
Total services per organization type	38	16	18	24	96



Table 5 indicates that ethno-specific urban services (Filipino-Urban) provided twice as many services compared to ethno-specific organizations (Filipino-Regional) in the regional and rural areas of Victoria. Overall, there were six organizations providing a wide variety of specialist services such as media, medical and other health related services, migration, and aged and disability related services.

Table 6

*Gender and Position in Organization*

	Women	Men	Total
Management	7 (35.0%)	7 (70.0%)	14 (46.7%)
Paid service provider	11 (55.0%)	2 (20.0%)	13 (43.3%)
Volunteer service provider	2 (10.0%)	1 (10.0%)	3 (10.0%)
Total	20	10	30

The CLs comprised 20 women and 10 men who were in either management positions or in their service provision roles within their organization. In this sample the majority of men (70.0%) were in management positions in their organizations, while more women (55.0%) were in service provision roles. Table 6 indicates there was approximately equal representation from both management (n=14) and direct service provider (n=13) in the CL sample.

### **Presenting Issues of Clients**

Table 7 reports the concerns and challenges of older Filipino clients as reported by the CLs. Overall, the primary concerns as perceived by the CLs in order of importance were: 1) access to services (73.3%); 2) health (70.0%); and 3) isolation and homesickness and migration and settlement (equally at 53.3%). The secondary concerns were: 1) aged care (50.0%) and 2) income and family relationship issues (equally at 40.0%).

Table 7

*Presenting Issues of Clients According to CLs*

	Filipino- Urban	Filipino- Regional	Mainstream- Urban	Specialist
Access to services	√	√	√	√
Health	√	√	√	√
Migrant and settlement	√	√		√
Isolation and homesickness	√	√	√	√
Aged care	√		√	√
Income	√			√
Family	√	√		√
Youth related issues	√	√		
Grandparenting	√	√		
Total	9	7	4	7

**Services Accessed by Elderly Filipino Women**

Services accessed by the Filipino community within each of the organizations are shown in Table 8. The CLs were asked to identify the existing services older Filipino clients access in their organization. As shown in Table 8, the CLs reported that older Filipino clients mainly accessed services on Information (93.3%), Language and cultural support (90.0%), Advocacy (60.0%) and Recreation (56.7%). Age care related services on (transport support and home visiting at 46.7% each) were the second group of services accessed by the older Filipino clients of the organizations in this study. CLs reported that older Filipino clients least accessed services on Personal support and health services (equally at 16.7%) home help (10.0%), and food services (6.7%).

Table 8

*Services Accessed by Filipino Clients*

	Filipino- Urban	Filipino- Regional	Mainstream- Urban	Specialist Services
Information	√	√	√	√
Language and culture	√	√	√	√
Advocacy	√	√		√
Recreation	√	√	√	√
Transport support	√	√	√	
Aged care	√		√	√
Home respite	√		√	
Home visiting	√	√		√
Migrant and settlement	√	√		√
Day care	√		√	√
Counselling	√			√
Health	√			√
Personal support	√			
Home help	√			
Food services	√			
Total	15	7	7	10

The CLs were asked about additional support required by older Filipino clients. As perceived by all groups of CLs, the three issues in order of importance were: (1) link to services; (2) improved access to services; and (3) providing cultural and linguistic support to older Filipino clients. The CLs reported linking older Filipino clients as being the most important additional support older Filipino clients needed in order to access relevant services. This is demonstrated in the following quote from two CLs:

A CL expressed the following: *“Service providers do not always provide appropriate services to Filipino clients because they (service provider) thought that they (Filipino clients) can write, read and speak English so, there is no need to use interpreter or people who speak Filipino; and Filipinos always miss out on these important services.”*

Another CL supported the above observation: *“The data from existing Filipino clients indicate that referrals came from hospitals, allied health services and actual family members. Most Filipinos who accessed the services indicated that English is the preferred language. This means that if councils and other services only use the criteria of language spoken at home as the basis for assessing the number of CALD clients, the number of Filipino clients may appear considerably lower. It is therefore important to look at both the language spoken and the country of birth to get a more reliable number of Filipinos within the service... There were instances where family members declined council services on behalf of the client. The usual reason given is that the family members would provide the support service.”*

A CL said that older Filipino clients require transport support and intergenerational support because of loss of elderly status and conflict with in-laws about money and care of grandchildren. A CL argued that there is a need to target the family members of clients to ensure that they are aware of the services available. Another CL in a management position stated that in their organization, *“The referral system in place works well, but if we don’t have appropriate staffing with increasing number of older Filipinos, there is no certainty that they can be provided with some assistance. Staffing should be commensurate with growing aged population.”*

The discussion amongst CLs as highlighted by the quotes above showed that there were many facets that needed to be addressed or considered in improving the older Filipino clients’ access to relevant services to meet their needs.

### **Supports and Barriers to Service Provision**

Community leaders were asked to discuss what made it easy or hard for them and their organisations to provide services to CALD backgrounds particularly Filipino community. Enablers and barriers to accessing services by Filipino community members are summarized in Tables 9 and 10.

Table 9

*Enablers to Service Provision*

	Filipino- Urban	Filipino- Regional	Local Council	Specialist Services
Agency/association characteristics, e.g accessibility, service type	√	√	√	√
Appropriate cultural linguistic support availability	√	√		√
Individual service provider characteristics, eg. attitudes, motivation to work, cultural competence	√			√
Volunteer from same cultural background	√			√
Client Characteristics, eg. language, motivation	√		√	√

The CLs reported that the clients' knowledge and understanding of the services, help-seeking attitudes and behaviour; and the organisations' provision of culturally and linguistically appropriate support and service, were equally important to access of services. The four groups of community leaders in this study all considered the provider's cultural and linguistic awareness and understanding and motivation to serve the Filipino community served as enabling access to services for Filipino clients. For example, a Filipino volunteer in an organization stated that,

*“ It is easy to provide services to older Filipinos because I understand Filipino culture and language, but, it is hard because of the distance to pick them up.”*

A community leader of a peak organization on the other hand stated,

*“Too many information on health and service but what does Filipino need the most?”*

Table 10

*Barriers to Service Provision*

	Filipino- Urban	Filipino- Regional	Mainstream- Urban	Specialist Services
Culture	√	√	√	√
Individual	√	√		√
Funding	√	√		√
Management	√	√		√
Demographics	√	√	√	

According to the four groups of CLs, culture was rated as the highest barrier for the organization to provide services to CALD backgrounds including the Filipino community. The leaders considered that 1) lack service providers' understanding of salient cultural beliefs, values and migration circumstances, and 2) trained workers from CALD backgrounds particularly in working with old people act as barriers to provision of services to CALD communities. Individual factors (lack of knowledge and understanding of services being provided), organizational factors (funding, management style), and geographical dispersion of Filipino elderly were also reported as barriers to service provision.

The following quotes from two CLs highlight the salient elements that are particular to the older Filipino clients in accessing services according to CLs in this study: *"The main concern of Filipino clients was not knowing enough information about services and how to access them."* *"The main problem of community leaders is the differences in their cultural approach because of different regions and different attitudes to services and leaderships even though they are from the same umbrella body. The fragmentation of the Filipino community just reflects the fragmentation of the Filipino community due to social and class structures. They bring along the problems in the Philippines and class structure society so it is difficult for elderly who grew up in that environment to adapt to egalitarian environment. So the problem with these people in going to mainstream services, they interpret things culturally*

*and class society. Although it is not stated in the document, the class division is manifested in the old age.”*

Two community leaders reported that for some women in their regional/rural areas, controlling husbands or women not allowed to join groups were additional barriers to access or provision of services to Filipino women residing in these area.

A community leader providing medical services to the Filipino community said she did not have problems because, *“I also speak the Filipino language but for other NESB/CALD groups, access to interpreters via phone or a relative can be time consuming or just difficult to get.”*

### **Summary of Stage 1: Community Leaders**

This consultation with community leaders elicited valuable information about their perception of presenting issues and use of services by the older Filipino community. Stage 1 revealed a number of common ethno-specific themes as perceived by community leaders from mainstream and ethno-specific organizations in urban and regional areas of Victoria. The primary concerns clients presented to all the organizations in this study were: 1) health; 2) access to services; and 3) isolation and homesickness. The secondary concerns were: 1) migration and settlement, 2) aged care, and 3) family related issues. The results of this preliminary study indicate that as perceived by the community leaders in this study, the needs of older overseas-born Filipino migrants in Victoria were dissimilar to those needs reported by researchers examining other overseas-born CALD communities (Thomas & Balnaves, 1993; Hugo & Thomas, 2002; Thomas, 2003, 2004; Wong and Ujimoto, 1998). The CLs reported that the presence of organizational factors (such as the culturally and linguistically appropriate provision of service by employing Filipino staff) and individual factors (such as staff attitudes, motivation, and cultural orientation in providing service) may act as enablers for Filipino women in accessing services. On the other hand the absence or lack of these

factors in some services may act as barriers to access services by other overseas-born CALD communities (Thomas & Balnaves, 1993). As expected, culture, language, and geographical dispersion act as barriers to service provision to older overseas-born Filipino migrants in their catchment area for regional, local councils and ethno-specific organizations.

The findings of this preliminary exploratory study tend to support previous findings (Sozomenou et al., 1999; Pablo & Braun, 1997; Xenos, 2000; Thomas, 1993, 2004; Jones et al., 2002; Sue, 2002; Thompson et al., 2002; Yu et al., 2004) that underutilization of social and health services by CALD communities are associated with multiple factors or resources such as lack of information about services/system, geographical distribution, transport problems, and cultural and linguistic appropriateness of the services that might be more accentuated for older Asian immigrants (Wong & Ujimoto, 1998; Wong et al., 2006).

Consultations with Groups 1 (CL) and 2 (FW) were aimed to highlight salient issues affecting middle age and older Filipino immigrant's health and patterns of service utilization. The results of this consultation with community leaders were then used to inform the open-ended questions to be asked the Filipino women in Victoria in Group 2. Further, the results of these two consultations informed the questionnaire used for the national survey in Stage 2.

## **Group 2: Filipino Women**

### **Filipino Women (FW) in Victoria**

This section discusses findings on the particular circumstances of 128 adult Filipino women migrants in Victoria. Specifically, this report highlighted the caregiving challenges confronting 57 older Filipino women who migrated either as young spouses/brides or as elderly grandparents but are performing primary caregiving roles in the family.

Several community groups were approached to encourage their individual members interviews were conducted with Philippine-born adult migrants in urban and regional areas of Victoria Australia.



Consultations with Groups 1 (CL) and 2 (FW) were aimed to highlight salient issues affecting older Filipino immigrant's health and patterns of service utilization. The results of these two consultations informed the questionnaire used for the national survey in Stage 2.

## **Method**

### **Filipino Women in Victoria**

A total of 128 overseas-born Filipino women in Victoria participated in 17 focus groups in Stage 1. These women migrated to Australia either as brides or spouses for either non-Filipino men or Filipino men and as grandmothers to help their family care for the grandchildren. The majority of these Filipino women (79.3%) were from Metropolitan Melbourne. The remainder (20.7%) were from regional areas (Gippsland and La Trobe Valley, Goulbourn Valley, Greater Bendigo and Ballarat, and Bellarine Peninsula).

The sample of 128 Filipino women was divided into three groups according to their reasons for migration to Australia: namely Filipino women who married non-Filipinos (Brides), Filipino women who married Filipinos (Spouses), and Filipino women who came to Australia as grandmothers (Grandmothers). Of the 128 overseas born Filipino women in Stage 1 of the study, 39.0 % were brides (n=50) married to non-Filipino men, 26.7 % of were spouses (n=34) married to Filipino men, and the remaining 34.3% were migrant grandmothers (n=44). The sample characteristics are reflected in Table 11 of the results.

### **Measures**

The questions included in the questionnaire for FWs were based on a review of the existing literature discussed in Chapter 2 regarding the concerns of ageing migrant communities in general, as well as consultation with a senior community leader with specialization in Filipino aged care. The questionnaire for the FWs included a plain language statement, a consent form, and a one-page open-ended questionnaire (Appendices F & G). The open-ended questionnaire asked the FWs about their demographic information (age,

gender, marital status, religion, birthplace in the Philippines, suburb/town currently residing in Australia, living arrangements), migration circumstances (year of migration, type of visa, reason for migration, concerns and expectations about migration, settlement and adjustment, language spoken at home), and primary caregiving experience.

As discussed in Chapter 5, using qualitative and quantitative methodology is recommended when conducting cross-cultural research (Green & Thorogood, 2009; Paterson & Britten, 2008; Mio et al., 2006; Salkind, 2009). Therefore careful consideration was given to recruitment of participants because of issues such as representativeness of the sample, access to participants, and language (Bailes et al., 2006; Chin et al., 2006; Huer & Sanz, 2003; Saint-Germain et al., 1993). For example, the researcher had to involve the community leaders and staff in recruiting participants, conducted interviews at regular community meetings, and at times conducted interviews in the residence of participants with some disability (e.g. hearing or mobility impairment).

The researcher also travelled to regional areas of Victoria to recruit Filipino women in order to make the sample more representative of the Filipino migrant population. The different methodologies and treatment frameworks were based primarily on indigenous Filipino psychology (Enriquez, 1993; Gonzales, 1995; Mio et al., 2006; Torres, 1995) to identify important stress and coping differences between the three groups of Filipino women.

## **Procedure**

A senior CL assisted with linking the researcher to various Filipino groups. In conducting research using focus groups, it is important to select participants that are able to provide insight into the topic being researched ( Halcomb et al., 2007). In the current study, participants needed to meet the following criteria: first, be a Filipina woman, second, born overseas, and third, over the age of 40-years residing in Australia. The study took a non-probabilistic, purposive sampling approach to recruit participants. Kitzinger (1994) argued

that the expression of different views is enhanced when pre-existing groups are used in focus group research because group members already have an established level of trust with each other. Therefore, samples were drawn from pre-existing Filipino associations in metropolitan and regional areas of Victoria.

The group interviews were conducted at the ethno-specific centre and Senior Citizen Centres in Metropolitan and regional areas in Victoria Australia in Bairnsdale, Bendigo, Traralgon and Moe. The interviews were conducted for up to 2-hour duration with a short break for older participants.

Filipino women were invited by their association officers to attend the meeting about this project. Most informants were referred to the researcher by mainly Filipino community leaders, aged care service providers, and some by wider informal social network. Participants signed letters of informed consent that were part of the research protocol approved by the RMIT Human Research Ethics Committee.

A series of open-ended questions were presented to all informants at the commencement of the interview. Some demographic data were collected in the individual participants' homes by the main researcher accompanied by a friend of the prospective participant and/or by a Filipino community leader in the area. To facilitate participation of people with different abilities, the semi-structured questionnaires were read to some participants who had low educational attainment and/or decreased reading or hearing or visual abilities due to old age.

### **Data Analysis**

Thematic content analysis was chosen as the analysis strategy to identify typical responses and salient issues raised by the Filipino women in Victoria in Stage 1 Green & Thorogood, 2009; Patterson & Britten, 2008; Mio et al., 2006; Salking, 2009). An inductive approach was used on gathering eliciting themes focusing on the presenting issues, use of

services, and enablers and barriers to access to services by older CALD migrants. Using thematic content analysis, data were categorised into recurrent or common themes by looking at each segment of text within a transcript and asking “what is this text *about*?” and “how is it *similar* and/or *dissimilar* to other segments of text?” Each segment of text was inductively coded into succinct themes that summarise the key elements within the respondents’ accounts (Green & Thorogood, 2009). The transparency of the analysis was illustrated by presenting extensive verbatim quotes in the result section of the current study. The common themes identified in Stage 1 were used to develop the demographic, concept of ageing and caregiving questions, and psychological measures for Stage 2.

## **Results**

### **Filipino Women in Victoria**

The total sample (n=128) was divided into three groups: Filipino women who married non-Filipinos (Brides, n=50), Filipino women who married Filipinos (Spouses, n=34), and Filipino women who came to Australia as grandmothers (Grandmothers, n=44) between 1972 and 2005. Demographic characteristics of the three groups are shown in Table 11 to indicate the differences within the groups.

The mean age for the total sample was 64.48 years, with 40 years as the youngest and 88 years as the oldest. Grandmothers mean age is 78.0 years compared to Intramarried mean age of 57.94 years and Intermarried mean age of 57.04 years. Fifty seven percent of the Filipino women were either married/ defacto (n=73), widowed (n=50) or divorced (n=5). The Filipino women were highly educated with 74.2% having University or Higher degrees (n=95). Thirty percent (n=39) are in employment, while the remaining majority (70%) of the total sample were either retired or not working. Twenty two percent (n=28) of the total sample declared other sources of income such as own business and investments.

Table 11

*Demographic Characteristics of Three Groups of Filipino Women in Victoria*

	Brides (B) N = 50		Spouses (S) N = 34		Grandmothers (G) N = 44	
	n	%	n	%	n	%
<b>Age group</b>						
40-49	11	22.0	6	17.6	0	0.0
50-59	22	44.0	14	41.2	0	0.0
60-69	9	18.0	12	35.3	2	4.5
70-79	6	12.0	2	5.9	24	54.5
80-89	2	4.0	0	0.0	18	40.9
<b>Marital Status</b>						
Married	33	66.0	29	85.3	11	25.0
Divorced/separated	4	8.0	0	0.0	1	2.3
Widow	13	26.0	5	14.7	32	77.7
<b>Education</b>						
Catholic	36	22.0	30	88.2	35	79.5
Primary and Secondary	5	10.0	3	8.8	25	56.8
<b>Religion</b>						
Catholic	36	22.0	30	88.2	35	79.5
Other Christian	11	22.0	1	2.9	6	13.6
Other	3	6.00	1	2.9	3	6.8
<b>Employment</b>						
Working	25	50.0	14	41.2	0	0.0
Retired	25	50.0	20	58.8	44	100.0
<b>Living arrangements</b>						
Alone	11	22.0	3	8.8	21	47.7
With family	38	76.0	31	91.2	23	52.3
With others	1	2.0	0	0.0	0	0.0
<b>Geographical location in Victoria</b>						
Urban	24	48.0	31	91.2	42	95.5
Regional/rural	26	52.0	3	8.8	2	4.5
<b>Birthplace type</b>						
Urban	26	52.0	13	38.2	11	25.0
Regional/rural	24	48.0	21	61.8	33	75.0
<b>Caregiver</b>	44	88.0	18	52.9	27	61.3

The Filipino women migrated to Australia between 1970s and mid-2000s. The peak of migration of the Filipino women was in the 1980s (57%) followed by the 1990s (26.6%), 1970s (12.5%), and 2000s (3.9%). More than half (58.6%) migrated under the Family reunion/Skilled migration visa, just over a quarter (26.6%) as bride/spouse/fiancée, and the

remaining (14.8%) as tourist/student/other categories. A quarter of the sample had visited Australia prior to migration contributing to nearly half of the total sample (48.4%) were very keen to migrate, 35.2% keen, and 16.4% were ambivalent or unsure.

Most of the participants (60.9%) were born in rural areas (n=78) in the Philippines. In contrast, majority of these migrants (75.8%) were residing in urban areas (n=97) of Victoria, Australia. Home ownership is at 57%; with living arrangements distributed as 71.9% live with partner/family/relatives (n=92); 23.2% live alone (n=35); and only .08% live with people not related to them (n=1). Fifty eight percent (n=75) speak both English and Pilipino/dialect at home, followed by (n=38) speaking mainly Pilipino/dialect, and a small group at (n=15) speaks in English only. A high proportion of the total sample (85.9%) were members of ethnic associations.

The majority of the sample (82%) reported that their migrations expectations were met. However 27.3% said they had the same initial adjustment challenges. For example, a 51-year old Filipina bride migrated in 1981 to marry her much older non-Filipino husband. They did not have children and she did not have other relatives in Australia. She said, *“A bit hard at first being far away from family.”* She confronted loneliness and the cold weather. At time of interview, she was still experiencing some loneliness which was exacerbated by becoming a caregiver for her aged husband who became disabled. She found her caregiving role very tiring and as she was not driving, transportation for her and her aged husband was a major problem for her. Another example was the experience of a 60-year old Filipina spouse who had a difficult adjustment in Australia. She migrated with her Filipino husband and their three young children in 1982. However, they did not have any other relatives in Australia and has not been successful in sponsoring other family members. She said, *“I found it extremely difficult because we did not have relatives...we were busy at work so we did not have time with children...(our) youngest son with depression so we can not leave him alone. I also*

*experienced depression.*” To help manage her depression and the burden of caregiving, she joined Filipino clubs, church and also engaged in voluntary work for the elderly. An elderly grandmother aged 74 years was a widow who was sponsored by her son so she could assist with minding the children while he and his wife worked. She arrived in Australia in 1998 but at the time of this research interview her application for permanent residency was still not resolved. This temporary status meant she was not entitled to age pension and therefore was still being financially supported (living expenses and private health insurance) by her son in Australia. Because of the financial support she needed from her son, she considered herself a burden to him because she had overheard arguments about her that supported this assumption.

A similar number (26.6%) were confronting some challenges at time of interview. For example, a 64 year old Filipina spouse who was a primary caregiver of her ageing husband who has multiple medical conditions said she had to “cut other unnecessary expenses” because of the increasing cost of medicine. For a 78-year old widow who cares for an adult child with disability, transportation has become a major challenge. For many elderly Filipino women like the 81-year old widow who migrated in 1981 to help her son and grandchildren, failing health was a major challenge as she aged in Australia.

Of the 128 Filipino women in this sample, 44.5% (n=57) were primary caregivers for their family in Victoria (Figure 10). Since this stage of the study was primarily focused on the experiences of the Filipino women in Victoria who migrated as brides and grandmothers and assumed primary family caregiving, the rest of this report highlighted the caregiving experiences of the 57 older Filipino women. Their experiences were paramount in the establishment of the framework for Stage 2 of this project and informed the future planning of services for ageing Filipino communities in Victoria. The results of Stage 1 were used by

the linkage partner to successfully get funding for community aged care packages for older Filipinos residing in the western and northern suburbs of Melbourne.

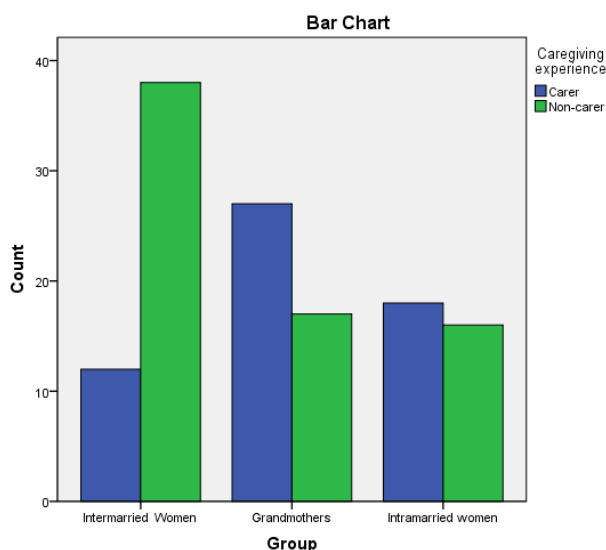


Figure 10. Distribution of Filipino women caregivers in the sample

### Challenges of Caregiving

Challenges reported by caregivers included not having enough time to perform multiple tasks, intergenerational differences between grandparents, adult parents and children, and hyperactivity of grandchildren. A grandmother said, *“Grandchildren are very active. Too many housework for me. I iron at night, work and cook during the day.”* The caregivers’ own ageing health, lack of income, and means of transportation exacerbated these challenges. Nine caregivers reported high levels of stress as a result of having to juggle employment, caregiving, ageing, housework, and raising their own children. An intermarried woman said, *“A tough undertaking that you are caring for your kin. It calls for a non-stop 24-hour work. Caring for husband makes me busy to find the right food –organic which makes it more expensive.”* Some participants who are already isolated because of their living arrangements and cultural background reported that caregiving was not only tiring but also isolating. A grandmother said, *“Initially, language problem with Australian son-in-law...not knowing clubs to go for recreation.”*



## Positives of Caregiving

Despite settlement adjustments inherent to migration and the challenges that are particular to Filipino brides/spouses and grandmothers, participants reported many positive aspects of caregiving for their family and others that encompass psychological resources (cultural values and beliefs, religiosity, filial duty, relational, intellectual, personal growth and practical rewards). The majority of the Filipino caregivers believed they possess the personal resources (coping and social) to successfully adapt to their caregiving role as they approach old age. A grandmother looking after grandchildren said, *“Makes me happy although sometimes they are naughty. Adult children give some money. Am able to teach children Filipino values and culture, Sunday as family reunion including girlfriends and boyfriends. We have close relationships.”* Another grandmother who lives with Australian son-in-law and her daughter said, *“I establish good relationship with Australian son-in-law who work(s) at night. I cook his favourite breakfast before I go out to meetings. Join Filipino clubs every weekend is my day off.”*

A husband’s caregiver said, *“Satisfaction to care for a loved one. My love does not falter because he is sick. I give spiritual support.”* She also said, *“Pray, talk to friends, join clubs, Filipino and church organizations that help me. Do volunteer work...go around shops, budget well...”*

A caregiver of a parent said, *“We want to make him happy in his remaining number of years of his life and as an example to our children, so that when we grow old they would do the same. I became more compassionate to people who are dying.”* While a caregiver of a spouse and a grandchild said, *“It gave me good understanding and appreciation of the health system and human services available.”*

## Resources and Caregiving

The majority of female caregivers in the present study showed a variety of personal and social resources to successfully adapt to a new country and various challenges inherent to the migration process such as changes in their roles, functions, social status, and general health. The psychological resources demonstrated by the participants include having a positive attitude, religiosity, sense of duty, filial obligation, family centredness, language proficiency, communication skills, education, and health. They reported accessing social resources like medical, allied health services and social support services provided by the mainstream and ethno-specific services. These findings tend to support Wong and Ujimoto's (1998) theory on developing resources to successfully adapt to environment.

Although most caregivers accessed social security services such as Centrelink ( $n=41$ ), and language and cultural support ( $n=24$ ), only a small number accessed aged cared related services ( $n=15$ ) and day care ( $n=10$ ), transport support and home help ( $n=9$  each), home visit and counseling ( $n=7$  each), respite ( $n=7$ ), and personal care ( $n=1$ ). Ethno-specific services described in Chapter 1 that were accessed by caregivers in the sample included the health and community care (HACC) services provided by the Filipino Community Council (e.g. Damayan, Day Care, and Friendly Visiting Program) and Filipino Church and social clubs. Only two caregivers accessed childcare/ playgroup services. All caregivers reported family and friends as sources of emotional, spiritual, socio-cultural, instrumental and practical support.

Although a great proportion of caregivers reported that their individual needs (73.24%) and the needs of their cared person (71.83%) were generally met by ethno-specific services, to complete their caregiving roles, the following themes emerged that require further exploration in a larger study to follow:

*“Caregivers should be given transport assistance, respite care, carer access to taxis, separate gatherings for caregivers, medical bulk billing on weekends”*

*“We need intensive outreach support services (provided) by professional who speak and understand Filipino cultural values...it’s easier to express ourselves and be understood in our native language as we get older.”*

*“Need a place where to go like babies group for grandparents.”*

### **Summary of Stage 1 Focus Groups with Filipino Women in Victoria**

Group 2 was a statewide qualitative open-ended interview of overseas-born Filipino women migrants in Victoria. The interview elicited discussion of issues the middle age and older Filipino migrants were facing and the personal resources they employ as they settle, age, and become family caregivers in Australia.

Most of the Filipino women had high education and competence in English. The majority spoke English and Pilipino at home. Although most of the Filipino women’s migration expectations were met, about a third of the sample reported initial settlement problems. Differences in spoken English, lack of recognition of their overseas qualifications and geographical isolation initially caused them stress. The majority of Filipino women reported that they were members of ethno-specific social clubs or local organizations and/or religious groups.

Results showed that nearly half of the Filipino women in this sample were in a primary caregiving role for spouse with health issues or to look after grandchildren so that adult parents could participate in paid work. Challenges reported by Filipino caregivers included not having enough time to perform multiple tasks, intergenerational differences between grandparents, adult parents and children, and hyperactivity of grandchildren. The caregivers’ own ageing health, lack of income, and means of transportation exacerbated these challenges. Some younger caregivers reported high levels of stress as a result of having to

juggle employment, caregiving, ageing, housework, and raising their own children. Some Filipino women who were already isolated because of their geographical location, living arrangements and cultural background reported that caregiving was not only tiring but also isolating.

Despite settlement adjustments inherent to migration and the challenges that are particular to migrant Filipino brides/spouses and grandmothers, the caregivers in this sample still reported many positive aspects of caregiving for their family and others that encompass psychological resources (cultural values and beliefs, religiosity, filial duty, relational, intellectual, personal growth and practical rewards). A majority of the Filipino women caregivers believe they possess the personal resources (coping and social) to successfully adapt to their caregiving role as they approach old age in Australia.

All caregivers reported family and friends as sources of emotional, spiritual, socio-cultural, instrumental and practical support. Most Filipino women caregivers accessed social support services, but only a small number accessed aged cared related services. Ethno-specific services accessed by Filipino caregivers in the sample included the health and community care services provided mainly by the Filipino Community Council and then the Filipino Church and social clubs. Only two caregivers accessed childcare/ playgroup services which may be explained by cultural factors as described by the study conducted by D'Mello & Esmaquel (1990) on childrearing and access to childcare practices by the Filipino migrants in Victoria.

Although a great proportion of caregivers reported that their individual needs and the needs of their cared person were generally met by ethno-specific services, to complete their caregiving roles, certain themes emerged that require further exploration in a larger study to follow. For example, caregivers articulated that they also needed some support such as respite care for both primary caregivers of adults and children, access to subsidized transport and

medical care particularly after hours, and social support. These assertions were supported by both Filipino women caregivers and non-caregivers in this stage of the study. They also articulated initiatives that they believed would assist kinship caregivers in performing their roles and also maintain expected optimum health given their unique individual make up as they themselves age in the new country. Suggestions included the following: 1) Respite for grandparents caring for grandchildren. This may be in the form of limiting the total hours of care during the day, or receiving home help, or having a day off on weekend; 2) Respite for caregivers of spouse or parent through home help; 3) Access to subsidized taxi/transport fare for caregivers; 4) Access to bulk billing for caregivers on weekends; 5) Child care centre run by Filipinos; 6) Grandchildren playgroups; 7) Grandparents support group; 8) Drop-in centre/day care run by Filipinos; 9) Retirement or nursing home for Filipinos managed by Filipinos.

In summary, the results of consultation with Filipino women in Victoria in Stage 1 of the research suggest that personal resources, family resources, and social support influence psychological health and perceived self-efficacy for brides and grandmother in primary kinship caregiving roles. Further research is clearly needed at the next stage of this project to identify additional important variables to the general health and wellbeing of old adult kinship care providers. Thus the caregiving questions were retained in Stage 2. This offered opportunity to investigate functioning of primary caregiving from diverse migrant, socio-economic groups and geographical locations.

### **Summary of Stage 1**

The interviews of both groups of community leaders (CL) and Filipino women in Victoria (FW) were designed to elicit discussion of issues the Filipino migrants were facing and the personal resources they employ as they settle and age in Australia. This preliminary stage revealed a number of common ethno-specific themes as perceived by service providers

as represented by community leaders and as reported by the migrant community of middle age and older Filipino women in Victoria.

### **Perceived needs as reported by CL and FW**

Overall the results of this preliminary study indicate that as perceived by the community leaders in this study, the needs of older overseas-born Filipino migrants in Victoria were not dissimilar to the needs expressed by the Filipino women in this stage of the study. The results also reflect those found with studies on many overseas-born CALD communities (Thomas & Balnaves, 1993; Hugo & Thomas, 2002; Thomas 2003, 2004) and as suggested by Wong and Ujimoto (1998) about the needs of the Asian elderly. The primary concerns clients presented to all the organizations in this study were: 1) health; 2) access to services; and 3) isolation and homesickness. The secondary concerns were: 1) migration and settlement, 2) aged care, and 3) family related issues.

### **Primary caregiving and resources**

With settlement adjustments inherent to the migration and the challenges that are particular to Filipino brides/spouses and grandmothers, it is expected that changes in family structures, roles, and living arrangements significantly impact on the future care needs of this ageing ethnic community.

The results indicate that the Filipino caregivers with high education, language competency, strong religiosity, firm sense of filial duty, family centredness, and positive attitude develop and maintain psychological and social resources to successfully adapt to the potential stressors of their caregiving role and identity as primary kinship caregivers.

The results also show that family-connectedness to be paramount in providing primary care particularly for grandchildren and spouses aspect of caregiving by the older Filipino women in this study. Community services are only accessed after tapping or exhausting the primarily preferred family resources.

The results tend to support literature on the influence of traditional Filipino values on a Filipino's appraisal of challenges and adaptation to changes in roles and environment (Butler, 2005; Jocano, 1997, 2006; Medina, 2001; D'Mello & Esmaguél, 1990; San Jose, 1995). Participants reported filial responsibility, family centredness, gratitude, love, respect, religiosity and inner strength are primary personal resources that enable kinship caregivers to meet the challenges of their roles. The kinship caregivers also make continuous adjustment of the values and expectations of themselves and their cared persons as they try to live by the standards of the original culture and the Australian culture.

### **Utilisation of social and health services by migrants**

The results in this preliminary exploration appear to support previous findings (Sozomenou et al., 1999; Pablo & Braun, 1997; Xenos, 2000; Thomas, 1993, 2004; Jones et al., 2002; Sue, 2002; Thompson et al., 2002; Yu et al., 2004) that underutilization of social and health services by CALD communities are associated with multiple factors or resources such as lack of information about services/system, geographical distribution, transport problems, and cultural and linguistic appropriateness of the services that might be more heightened for older Asian immigrants (Wong & Ujimoto, 1998; Wong et al., 2006) e.g. the older Filipino migrants in Australia.

### **Support for Resource-congruence model of adaptation**

The results of interviews with both groups of informants (CL and FW) in Stage 1 of the project suggest support of Wong (1993) and Wong & Ujimoto's (1998) resource-congruence model of adaptation that strongly posit that stress occurs in a cultural context and that successful adaptation starts with the development of various types of resources particularly personal resources. The findings of this preliminary exploratory stage also appear to suggest a model that shows that levels of psychological health can, in part, be explained by resources – personal (physical health, coping styles, acculturation strategies, education,

marital situation) and social environment (family, community, culture, religion, and social support) warrant further investigation in Stage 2 of the study.

The model to be examined in the national study has implications for practice and policy. Decreasing psychological stress is critical to the well-being of both the primary kinship care providers (brides & grandmothers) and the recipient of care as kinship caregivers typically do not receive the same economic compensation as non-relative foster/childcare providers.

### **Implications for Further Research**

Data gathered in this phase was used to develop the Filipino Caregiving Experience used in the second stage of the study. In order to get a more representative sample in the bigger study, stratified sampling and increasing recruitment from regional areas to include Geelong, Ballarat, Mildura in Victoria, and interstate such as South Australia, NSW and Queensland, was implemented. The researcher used peak national Filipino Community Associations in Australia's bi-annual convention to introduce the phase two of the project for interstate community leaders to invite and encourage their membership to participate in the national project.



## **Chapter 7: Stage 2: An Examination of the Acculturation and Wellbeing of Filipino Women Across Australia**

### **Overview of the Study**

Study 2 was a national study investigating the acculturation and mental health of Filipino-born female migrants in Australia. Specifically, the study investigated the role of cognitive and cultural mediators in the adaptation process. Previous research has shown that coping styles and personal resources (comprising perceptions of social support, acculturation level, and socio-demographic variables) are central predictors of mental health and wellbeing (AIHW, 2008, 2011a; Heath & Thomas, 2006). According to Folkman and Lazarus (1984), healthy adaptational outcomes comprise of functioning across three key areas: physiological, psychological, and social domains. Mental health was of key interest in the present study and was assessed in terms of self-reporting of three states of stress, anxiety and depression (DASS), coping strategies (Brief-COPE), perceived social support (SS-A), acculturation level (SASH), and degree of service utilisation.

Findings by Butler (2002) have suggested that strong familial, social and community support, meaningful relationships, and a healthier physical environment enhance the mental health of older Filipino migrants. Specifically, middle-aged and elderly Filipinos' appraisal of stress, ageing, migration, loneliness, and coping have been linked to three sets of variables: (1) socio-cultural factors, (2) familial support, and (3) social and community resources. These findings lend support to the resource-congruence model of adaptation developed by Wong (1993). Wong was one of the early coping theorists who strongly argued the significance of the cultural context in coping, and developed the resource-congruence model of adaptation for the Asian elderly (Wong & Ujimoto, 1998) and later the contingency model of cultural competencies (Leong & Wong, 2003). This model suggests that coping efficacy depends on:

(a) sufficient coping resources; (b) multicultural competencies of what works in which situations, and which coping goals are valued in which culture; and (c) the selection of coping goals and responses that are appropriate to the situation and the cultural context (Wong, Wong et al., 2006). Wong (1993) proposed that successful adaptation for an individual starts with the development of various types of personal resources for the individual and moves to the later anticipation of potential problems or stressors. Development of personal resources comes from past experiences, the establishment of friendship groups, building support networks, helping others, and increasing inner resources such as mental and spiritual health.

According to the resource-congruence model (Wong, 1993), when individuals are faced with a stressful encounter, they rationally assess their resources and the nature of the stressors and engage in some type of coping strategy. If these coping strategies are successful, the individual is then able to conserve their resources, ultimately improving their long-term mental health. The implication of this model is that for successful adaptation following a stressor, one must develop and maintain a sufficient stock of personal resources.

Apart from cognitive appraisal, Wong's (1993) model also proposes that individuals of non-Western backgrounds also engage in existential coping, which involves an acceptance of what the individual cannot change and finding positive meaning in a stressful event, and transformational coping, which includes spiritual transformation, rather than instrumental coping which is commonly used by individuals from Western cultures. In addition to cognitive appraisal and existential and transformational coping, proposed by Wong in his model, other researchers (Klassen et al., 2006; Pergament et al., 2004) have also shown that religious beliefs can also facilitate adaptation in non-Western individuals. For example, for the Filipino migrants in the current study, religion was in fact shown to be a fundamental element strongly embedded within the culture and closely linked to positive adaptation. Therefore, it is imperative that the model of successful coping includes religion.

As highlighted in the review of the literature, stress and coping models that have predominantly focused on Euro-American values and instruments are not always relevant to other cultures, and exclude religion as an important factor (Slavin et al., 1991). Thus, Wong's (1993) resource-congruence model of adaptation stands out to be the most relevant for the purpose and target group of this study.

Therefore, following Wong's (1993) resource-congruence model of coping, the personal variables included demographic data, category of migration, year of arrival, age, gender, spiritual or religious beliefs, and caregiving experience; the environmental resources included family, work, income, living arrangements, and social support; and life events such as physical and mental illness, occupational problems, racial discrimination, financial hardship, family problem, caregiving or grandparenting, which enabled participants to be assigned into one three groups for the study: intermarried brides (B), intramarried spouses (S) and grandmothers (G). To determine whether there were differences in social and adaptation resources and mental health between the three groups, a series of analyses of variance was conducted. This was followed by regression analyses to identify the predictors of mental health, positive settlement, successful ageing, and social support utilisation across the three groups.

The results from Stage 1 (Community Leaders and Philippines-born female migrants in Victoria) informed the framework for the national survey (Stage 2) conducted across five Australian states. Thus, Study 2 was a national study investigating the acculturation and mental health of Filipino women in Australia.

## **Method**

### **Sample**

A total of 282 overseas-born Filipino women ranging in ages from 40 to 89 years were recruited for participation in this Stage of the study. The Filipino women were residing in

both urban and regional areas across five Australian States (Victoria, New South Wales, Queensland, South Australia and Tasmania). These women migrated to Australia either as brides or spouses for either non-Filipino men or Filipino men or as grandmothers to help their family care for the grandchildren. These Filipino women migrated to Australia between 1961 and 2006, and were classified into three groups Filipino women who married non-Filipinos (Group B = Brides,  $n = 139$ , mean age = 52.87,  $SD = 11.98$ ), Filipino women who married Filipinos (Group S = Spouses,  $n = 91$ , mean age = 53.40,  $SD = 9.14$ ), and Filipino women who came to Australia as grandmothers (Group G = Grandmothers,  $n = 52$ , mean age = 77.90,  $SD = 6.22$ ). Demographic and background information for participants are reported in the Results section of this chapter.

As observed in Stage 1 and consistent with the existing cross cultural literature (Chin et al., 2006; Guerin & Guerin, 2007), participants were usually more willing to participate in research when encouraged by their community leaders. Hence recruitment procedures for migrant groups that were useful in Stage 1 were incorporated into Stage 2 (Guerin & Guerin, 2007). Specifically, following ethics approval by the University, community leaders were consulted about how best to conduct the recruitment procedure (Owen, 2001; Trimble & Mohatt, 2006; Xenos, 2000) in keeping with cultural concerns (Castro et al., 2006; Enriquez, 1993). Recruitment was preceded by meetings with the community leaders identified by the senior community leader. During these meetings, the study aims and research methodology were discussed, and copies of plain language statements, consent forms, and evidence of ethic approval documents were provided.

Most participants were recruited through Filipino aged care services, Filipino seniors clubs, state and national key organisations for Filipino migrants in Australia (e.g. FCCVI and FECCA), various Filipino interest groups and church groups. With the assistance of a senior community leader, the snowball recruitment method was used to access older people who

were not members of any Filipino associations, particularly those in regional or rural areas. Snowballing has been proven effective in cross-cultural research for finding and recruiting groups that are not accessible to researchers through other sampling strategies (Guerin & Guerin, 2007; Owen, 2001; Xenos, 2000).

## **Measures**

A questionnaire booklet comprising of conceptually related dimensions of settlement, acculturation, ageing, caregiving, mental health, coping and social support was developed for Stage 2 (Appendices I & J). The questions included in the questionnaire were based on the existing literature regarding the concerns of ageing communities in Australia as well as from the results of the Stage 1 focus group interviews with Community Leaders and Filipino women in Victoria.

The questionnaire booklet comprised:

- 1. *Personal Information Questionnaire:*** A demographic questionnaire was designed to identify personal characteristics of the participants, including year of arrival and visa category, age, sex, highest education attained, religion, marital status, number of children in Australia and in the Philippines, reason for migration, living arrangements, sources of income, care and support.
- 2. *Filipino Experience Questionnaire:*** The FEQ was developed on the basis of the results of Stage 1 and a review of literature. The FEQ comprised questions with numerical rating scales. Inclusion of middle, non-committal answers like “Not applicable” and “Other” was considered in the design of the questionnaire. The FEQ explored issues applicable to the older Filipino population, specifically experiences during the initial settlement period, subsequent integration into the community, use of health information and services, preferred support services when aged, preferred cultural background of aged care service providers, social ties, and the concept of ageing.

Additional questions for participants who were primary carers explored issues relating to their caregiving experience and access to psychological and social resources for support.

**3. *The Short Acculturation Scale for Hispanics (SASH) (Marin et al., 1987): 12 items:***

The SASH was adapted to create the Short Acculturation Scale for Filipino Americans (SASFA) (Dela Cruz et al., 2000). This adaptation was then used for Filipino Australians in this study. The SASH self-administered acculturation scale includes 12 items that relate to three factors: language use (5 items measuring language use and preference at work, home and with friends), media (3 items measuring media language use and preference), and ethnic relations (4 items measuring ethnic preference of individuals in social relations). For the eight language and media items, response options were 1 = *only Pilipino/Dialect*, 2 = *more Pilipino/Dialect than English*, 3 = *both equally*, 4 = *more English than Pilipino/Dialect*, and 5 = *only Pilipino/Dialect*. For the 4 ethnic and social relations items, the response options were 1 = *all Pilipino/Dialect*, 2 = *more Pilipino/Dialect than Australians*, 3 = *about half and half*, 4 = *more Australians than Pilipino/Dialect*, and 5 = *all Australians*. Scores ranged from 12 to 60 with high scores representing a higher level of identification with the host culture. The SASH measure was chosen for several reasons. First, the SASH is widely used in cross-cultural research on Hispanics, Anglo-Americans and Asians. Second, it has a reliability coefficient  $\alpha = .92$ . Third, this measure was adapted in a Filipino-American study by Dela Cruz and colleagues (2000) and has good psychometric properties, with overall Cronbach's alpha coefficient for internal consistency of .86 for the sample in the current study.

**3. *Depression Anxiety Stress Scales (DASS21) (Lovibond & Lovibond, 1995): 21 items***

The Depression Anxiety Stress Scales – 21 is a 21-item shortened version of the 42-item DASS scale. The DASS assesses the current state or change in state on three dimensions of emotional disturbance: depression, anxiety and stress. Examples of items are “I found

it hard to wind down” and “I tended to overreact to situations”. Participants are required to respond to each item on a four-point Likert-type scale ranging from “Did not apply to me at all” to “Applied to me very much or most of the time”. Total sum scores range from 0 to 160, with higher scores indicating increased levels of depressive, anxiety, or stress symptoms. The DASS has been validated and normed in measuring risk for depression, anxiety and stress in the Asian population (Musa, Fadzil & Zain, 2007). It is available in many languages and is widely used in both clinical and non-clinical populations (Norton, 2007). The DASS has convergent validity with the Beck Depression Inventory and Beck Anxiety Inventory of .74 and .81 respectively (Crawford & Henry, 2003), and a Cronbach’s alpha of .93 for the sample in the current study.

**4. *Brief-COPE (Carver, 1997): 28 items:*** The Brief-COPE is a 28-item version of the 60-item COPE (Carver et al., 1989) designed to measure coping responses known to be relevant to effective and ineffective coping. Items are presented as self-predicated responses to stress such as “I get upset and let my emotions out” and “I laugh about the situation”. The participant is required to respond to each item on a four-point Likert type scale ranging from “I usually don’t do this at all” to “I usually do this a lot”, with higher scores indicating greater use of that coping resource. For this study, the Brief-COPE was chosen because of its value in health-related research and its brevity in measuring 14 conceptually differentiable coping reactions that include those that are distinct to Filipinos in general such as religion and humour (Butler, 2002; D’Mello & Esmaguél, 1990; San Jose, 1995). The Brief-COPE has demonstrated internal reliability with Cronbach alpha of .89 for the sample in the current study.

**5. *Social Support Appraisals Scale (SS-A) (Vaux et al., 1986): 23 items:*** The SS-A was used to measure subjective appraisals of support resources and interactions identified in Wong and Ujimoto’s resource-congruence model of adaptation. This 23-item

questionnaire asks participants to indicate on a four-point Likert scale ranging from “1 = Strongly disagree” to “4 = Strongly agree” how much they believe that they were loved by, esteemed by, and involved with family members, friends and others. The scores are typically computed separately for the three subscales: support by family members (8 items), support by friends (7 items), and support by others (8 items). Low scores equate to high support. The SS-A has demonstrated internal reliability of Cronbach’s alpha of .90 for the sample in the current study.

The questionnaire package also included a plain language statement and a consent form, which was available in two languages, Pilipino and English.

## **Procedure**

As previously discussed in Chapter 5, there are a number of common methodological issues usually encountered in conducting a cross-cultural research, including representativeness of the sample, access to participants, and language; these need to be carefully considered in designing research that is as culturally and linguistically appropriate as possible (Bailes et al., 2006; Barrett & Parker, 2003; Enriquez, 1993; Gonzales, 1995; Green & Thorogood, 2009; Guerin & Guerin, 2007; MacKenzie et al., 2007; Mio et al., 2006; Paterson & Britten, 2008; Paterson et al., 2008; Torres, 1995). Therefore, using a similar format to that utilised in Stage 1, the researcher involved the assistance of a senior community leader in recruiting participants, and conducting interviews at both community settings, and in participants’ residences if participants had a hearing or mobility impairment. The researcher travelled to five Australian states to recruit Filipino women in order to make the sample more representative of the Australian Filipino migrant population.

Individual interviews were conducted for up to one-hour’s duration with a short break for older participants. Older Filipino men and women were invited by their community leaders to attend the meeting about this project. Participants either gave verbal or signed



letters of informed consent, which were part of the research protocol approved by the RMIT Human Research Ethics Committee. They were briefed about the study's aims, given a copy of the plain language statement (PLS) to read, and had summarised for them the information in the PLS ensuring that they were aware of their rights to privacy and confidentiality, and had all the information required to make an informed decision about their participation.

### **Data Analysis for Stage 2**

Questionnaire packages that were completed and returned were numbered and then using the Statistical Package for Social Sciences (SPSS version 15) software, data were coded and entered. Data cleaning and screening was conducted on the data set. In cases where respondents failed to answer one or more questions, the missing data were omitted in the analysis. The remaining responses provided by these respondents were entered according to the predetermined criteria (e.g. social support, acculturation).

Quantitative data was analysed using the Statistical Package for Social Sciences (SPSS version 15). Analyses were based on the three grouping categories. Between-group differences on continuous variables were analysed using paired sample *t*-tests. Analysis of variance (ANOVA), multivariate analysis of variance (MANOVA), and regression analyses (Tabachnick & Fidell, 2001) were then conducted to re-examine the relationships between mental health and several variables (e.g. age, migration pattern, acculturation level, coping style, social support).

The variables identified to be of interest to the participants in the current cross-sectional research were examined once the relationships between them were determined. To determine whether there were differences in these measures among the three groups of Philippine-born migrants in Australia, a series of Analyses of Variance (ANOVA), and Regression Analyses were conducted. Multiple regression modelling was used to identify the

predictors of positive settlement, successful ageing, and health service utilisation of the sample in the study.

For adaptational outcomes, stress-coping theory defines three domains: Physiological, Psychological and Social. For the present study, the psychological outcome was of major interest and was assessed in terms of self-reporting of levels of stress, anxiety, depression (DASS21) and ways of coping (Brief-COPE and SS-A).

The major concern of the study was the role of cognitive and cultural mediators in the adaptation process. Therefore coping and personal resources were central predictors in the research. Dispositional social support, acculturation, and socio-demographic variables were examined as co-variates in the present study. The mediating variables selected for investigation were coping resources of psychological health, education, spiritual, financial, cultural, environment and social support.

Coping resources were operationalised using Brief-COPE and SS-A. Beliefs about personal control were operationalised by a situationally specific measure of older persons' perception of their preferred place, type of services and service providers in their old age and certain questions in the coping scales. Coping resources provide data for the person to evaluate when they are appraising a transaction and as the basis of coping actions.

Following Wong's (1993) resource-congruence model of coping, the explanatory variables included demographic data, category of migration, year of arrival, age, gender and caregiving experience that enabled participants to be assigned into one of the three groups in the study: intermarried brides, intramarried women and grandmothers. Outcome variables included emotional health measures on depression, anxiety, and stress (DASS21). The influences of settlement experiences, acculturation (SASFA), coping strategies (Brief-COPE), perceived social support (SS-A), and degree of health service utilisation were explored in the model.

The researcher then conducted in-depth follow-up interviews with eight intermarried Filipino women in order to gather a more meaningful picture of the intermarried brides' migration experience and marital relationships. The qualitative data was analysed using thematic analysis. The summary of the interviews are presented at the end of this chapter.

## **Results**

### **Sample Characteristics Across Each of Three Participant Groups**

Of the 282 overseas-born Filipino women in Stage 2, 49.3% ( $n = 139$ ) were intermarried brides married to non-Filipino men (Group B), 32.3% ( $n = 91$ ) were spouses married to Filipino men (Group S), and the remaining 18.4% ( $n = 52$ ) were migrant grandmothers (Group G). Demographic characteristics of the three groups of women are shown in Table 12.

#### **Age.**

The age of the total sample ranged from 40 to 89 years. Approximately 65% of participants were aged 40–59 years, with the remaining 35% aged 60–89 years. An analysis of variance revealed that the groups differed significantly with respect to age,  $F(2, 279) = 202.83, p < .001$ . Post hoc comparison of estimated marginal means based on Bonferroni adjusted  $\alpha$  levels indicated that grandmothers (Group G) were significantly older than both brides (Group B) and spouses (Group S).

#### **Marital status.**

Just over 67.4% ( $n = 190$ ) of the total sample were either married/defacto, widowed (23.4 %,  $n = 66$ ), or divorced (9.2%,  $n = 26$ ).

#### **Education.**

Approximately 70% of the sample had obtained a university or higher degree while the remaining 30% had primary/secondary or TAFE qualifications. Independent samples  $t$ -tests revealed a significant difference between groups in education level, with Group S achieving a

higher education level than Group B,  $t(228) = 5.64, p < .001$ ; and Group G,  $t(189) = 5.40, p < .001$ . Post hoc comparison of estimated marginal means based on Bonferroni adjusted  $\alpha$  levels indicated that grandmothers (Group G) had a significantly lower educational achievement level than both brides (Group B) and spouses (Group S) as shown in Table 12.

### **Religion.**

The majority (85%,  $n = 240$ ) described themselves as Catholics, while the remaining 15% reported practising other religions including Islam.

### **Income.**

The two main sources of income for the sample were employment/investment (58.2%), followed by government pension (37.6%). The remaining 4.3% of the sample had no source of income. One of the reasons cited for not having any source of income was (a) due to their migration to Australia in old age and the fact that they were not eligible to receive the age pension because they had been in Australia for less than 10 years and (b) the women did not have any source of income because they were either full-time housewives and/or dependents of a working-age husband.

### **Migration history.**

Most migrants immigrated in the 1980s (46.1%) followed by the 1990s (29.4%), 1970s (7.7%) and 2000s (6.7%). Nearly half of the total sample (43.3%) migrated under a bride/spouse/fiancée visa. Less than twenty per cent (19.9%) migrated under the Family Reunion visa, while just over twenty per cent (20.2%) migrated under Skilled migration visa, and the remaining (16.7%) as tourists/students/other categories. Apart from the main reasons for marriage ( $n = 127, 45\%$ ) or to care for grandchildren ( $n = 44, 15.6\%$ ), the other reasons for migration reported by the sample were for better employment, financial security or education of their children ( $n = 111, 39.4\%$ ).

Twenty-one per cent ( $n = 60$ ) of the sample had visited Australia prior to migration.

Nearly half of the total sample (47.5%) were very keen to migrate, 38.3% keen, and 14.2% ambivalent or unsure.

### Years in Australia.

The number of years in Australia for Group B ranged from less than 1 year to 45 years; for Group S from less than 1 year to 35 years; and for Group G from 1 year to 29 years. There was no significant difference between Groups B, S and G in the mean number of years that they had been in Australia, (Group B mean = 20.33 years, SD = 7.90; Group S mean = 18.42 years, SD = 8.67; Group G mean = 15.83, SD = 6.20).

Table 12

### *Demographic Characteristics of Three Groups of Filipino Women Across Australia*

	Brides N = 139		Spouses N = 91		Grandmothers N = 52	
	n	%	n	%	n	%
<b>Age group</b>						
40–49	51	36.7	34	37.4	0	0.0
50–59	66	47.5	33	36.3	0	0.0
60–69	16	11.5	22	24.2	7	13.5
70–79	6	4.3	1	1.1	25	48.1
80–89	0	0.0	1	1.1	20	38.5
<b>Education</b>						
Primary – Secondary	45	32.4	3	3.3	38	73.1
University – higher	94	67.4	88	96.7	14	26.9
<b>Years in Australia</b>						
1–10	13	9.4	17	18.7	11	21.2
11–20	58	41.7	42	46.2	33	63.5
21–30	54	38.8	22	24.2	8	15.4
31+	14	10.1	11	11.0	0	0.0
<b>Type of birthplace</b>						
Urban	36	25.9	38	41.8	15	28.8
Regional	103	74.1	53	58.2	37	71.2
<b>Location of current address</b>						
Urban	68	48.9	82	90.1	51	98.1
Regional	71	51.1	9	9.9	1	1.9
<b>Current accommodation</b>						
Own	110	79.1	77	84.6	5	9.6
With children/other	8	5.8	5	5.5	28	52.8
Renting/nursing home	21	15.1	9	9.9	19	36.5

<b>Living arrangements</b>						
Alone	14	10.1	4	4.4	17	32.17
With family	59	42.5	52	57.1	0	0.0
With spouse	49	35.3	31	34.1	11	21.2
With grandchildren	9	6.5	1	1.1	23	44.2
With others	8	5.7	3	3.3	1	1.9
<b>Source of income</b>						
Wages/investment/other	91	65.5	70	76.9	3	5.8
Pension	45	32.4	17	18.7	44	84.6
No income	3	2.1	4	4.4	5	9.6
<b>Employment</b>						
Employed	82	59.0	69	75.8	0	0.0
Retired/not employed	57	41.0	22	24.2	52	100.0
<b>Employment prior migration</b>						
Yes	108	85.1	78	85.7	10	19.2
<b>Year group arrived</b>						
1960–1979	26	18.7	20	22.0	4	7.7
1980–1989	72	51.8	36	39.6	22	42.3
1990–1999	36	25.9	23	25.3	24	46.2
2000–2006	5	3.6	12	13.2	2	3.8
<b>Number of children in Australia</b>						
0	37	26.6	10	11.0	2	3.9
1–2	78	56.1	47	51.6	30	58.8
3–4	22	15.8	31	34.1	12	23.5
5+	2	1.4	3	3.3	7	13.7
<b>Religion</b>						
Catholic	116	83.5	79	86.8	45	86.5
Other	23	16.5	12	13.2	7	13.5
<b>Marital status</b>						
Married	95	68.3	81	89.0	14	26.9
Separated/Divorced	22	15.8	4	4.4	0	0.0
Widowed	22	15.8	6	6.6	38	73.1
<b>Visit to Australia prior migration</b>						
Yes	18	12.9	13	14.3	29	55.8
No	121	87.1	78	85.7	23	44.2
<b>Level of interest in migrating to Australia</b>						
Very interested	64	46.0	40	44.0	30	57.7
Interested	56	40.3	33	36.2	19	36.5
Unsure	19	13.7	18	19.8	3	5.8

### Geographical location.

Just over 71.3% (n = 201) of women were residing in urban areas and the remaining 28.7 % (n = 81) were in regional areas of Australia, while 31.6% were born in urban areas

( $n = 89$ ) and 68.4% ( $n = 193$ ) were born in regional and rural areas of the Philippines.

Independent samples tests showed that there were significant differences between the three groups, with a significant difference between groups B and S,  $t(228) = 7.05$ ,  $p < .001$ , and between groups B and G,  $t(189) = 6.56$ ,  $p < .001$ , indicating that more participants from groups S and G resided in urban areas compared to group B participants. No significant difference was noted between groups S and G,  $t(141) = 1.81$ ,  $p = .07$ , with both generally residing in urban areas.

### **Number of children.**

The results of independent samples  $t$  test results showed that there were significant differences between the three groups in the number of children in Australia. 78% of the sample had between 1 to 5 children. The majority (65%) had 1–2 children. Both groups S ( $t(228) = 4.52$ ,  $p < .001$ ) and G ( $t(189) = 4.88$ ,  $p < .001$ ) had significantly more children in Australia than group B; while there were no significant differences between groups S and G,  $t(141) = 1.31$ ,  $p = .19$ . Across all three groups, 20% of the total sample had children living outside Australia. Thirty-two per cent lived with their partner, 50.8% with family/relatives; 12.4% lived alone; and 4.3% lived with other people.

### **Age and Educational Level of Partners of Participants**

The age of the partners of the total sample ranged from 39 to 94 years with a mean age of 63.43 years,  $SD = 14.13$  years. The analysis of variance showed that the partners of the three groups of women differed significantly with respect to age  $F(2, 281) = 72.82$ ,  $p < .001$  and education  $F(2, 281) = 42.24$ ,  $p < .001$ . The results of independent samples  $t$ -tests and post hoc comparisons showed that partners of group B (mean = 62.86 years) were significantly older than partners of group S (mean = 55.25 years),  $t(228) = 5.05$ ,  $p < .001$ , and partners of group G (mean = 79.31 years) are significantly older than partners of groups B,  $t(189) = 8.24$ ,  $p < .001$ , and partners of group S,  $t(141) = 12.58$ ,  $p < .001$ . Independent samples  $t$ -tests and

post hoc comparisons revealed that partners of group S (mean = 1.86, SD = 0.36) were significantly more educated than partners of group B (mean = 1.33, SD=0.47),  $t(228) = 8.84$ ,  $p < .001$  and partners of group G (mean = 1.33, SD = 0.47),  $t(141) = 7.35$ ,  $p < .001$ .

### **Caregiving Across the Three Participant Groups**

A third of the sample ( $n = 93$ ) reported that they provided caregiving to at least one family member. Of the care recipients, 43.0% were spouses; 30.1% a grandchild; and 19.4% a combination of spouse/grandchild/others, while 7.5% cared only for their parents. Sixty-seven per cent of the participants were residing with the cared persons with the length of caring range from 1 to 22 years (mean = 6.5 yrs). The main reasons for becoming a caregiver were (1) due to illness (53.9%); (2) to look after grandchildren to enable parents to participate in paid employment (32.0%); (3) “*Utang na loob*”, that is, debt of gratitude, because they sponsored the caregiver to migrate to Australia (11.5%); and (4) Other reasons (2.6%). Half (51.6%) of the caregivers reported accessing social support services to assist them in their caregiving roles.

### **Outcome Measures Across the Three Participant Groups**

#### **Acculturation**

The 12 items used in the short acculturation scale were rated on a five-point scale from 1 to 5, with total scores ranging from 12 to 60. The raw scores were then converted to  $t$ -scores to use in the analysis. A one-way analysis of variance (ANOVA) was conducted to evaluate the relationship between the pattern of migration and the type of acculturation levels of the Filipino women. The independent variable included the three groups (B, S, G), while the dependent variable, the level of acculturation, included three levels of acculturation: low, moderate and high. High acculturation levels indicated increased preference for the English language, Australia media and social relations.



Table 13

*Acculturation Means and Standard Deviations of Different Scales for Different Groups Using t-scores*

Group	Mean	SD	95 % Confidence Interval	
			Lower	Upper
Brides	49.58	6.11	48.51	50.66
Spouses	45.31	5.56	43.98	46.64
Grandmothers	40.27	8.43	38.51	42.03

The results of a one-way ANOVA were significant,  $F(2, 279) = 41.86$ ,  $p < .001$ , with acculturation levels differing across groups. Follow-up tests using multivariate tests were conducted to evaluate the differences among the means, with a significant difference in acculturation levels,  $\Lambda = .77$ ,  $F(4, 558) = 19.97$ ,  $p < .001$ ,  $\eta^2 = .13$ . Table 13 shows the brides reported the highest levels of acculturation, while the elderly grandmothers reported the lowest levels of acculturation, indicating Group B (brides) had a more Australian disposition than Filipino women married to Filipinos (Groups S and G).

### **Mental health**

Table 14

*DASS Means and Standard Deviations of Different Scales for Three Participant Groups*

	Brides		Spouses		Grandmothers		Standard	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Depression	4.27	3.38	3.51	4.40	3.92	4.05	6.14	6.92
Anxiety	3.71	3.45	3.59	4.34	3.94	4.71	4.80	5.03
Stress	5.33	3.61	4.64	4.09	5.48	4.70	10.29	8.16

Tests were conducted to compare the sample means against normative population means by sex in the depression, anxiety and stress scales. Results of the MANOVA indicate that there was no statistically significant difference between groups for depression, anxiety and stress. All groups reported a normal range of symptoms in all the scales of measurement of mental health as shown in Table 14.

### Coping Strategies

A MANOVA was conducted to compare the three group sample means on the 14 coping scales. Significant differences were found between the three groups on coping measures, (Groups B, S, G),  $\Lambda = .761$ ,  $F(28, 532) = 2.78$ ,  $p < .001$ ,  $\eta^2 = .13$ . Table 15 contains the means, standard deviations from the coping subscales, as well as the results of the MANOVA across the three groups.

Table 15

*Coping Style Means, Standard Deviations and Group Variability on 14 Subscales Across Three Participant Groups*

Scales	Brides		Spouses		Grandmothers		<i>F</i>	<i>p</i>	$\eta^2$
	Mean	SD	Mean	SD	Mean	SD			
Emotional support	5.31	1.67	5.47	1.75	4.27	1.57	9.43	<.001**	.06
Positive Reframing	5.69	1.74	5.97	1.67	4.92	1.89	6.05	.003*	.04
Religion	6.30	1.79	7.00	1.30	6.88	1.66	5.83	.003*	.04
Instrumental support	5.26	1.70	5.20	1.63	4.37	1.77	5.66	.004*	.04
Self-blame	3.98	1.52	3.57	1.46	3.23	1.21	5.62	.004*	.04
Active coping	5.85	1.88	6.40	1.53	5.58	1.65	4.43	.013*	.03
Planning	5.94	1.68	6.07	1.49	5.27	1.78	4.27	.015*	.03
Substance use	3.40	1.27	3.16	1.08	3.50	1.35	1.51	.223	.01
Acceptance	5.80	1.67	5.92	1.55	5.40	2.22	1.50	.224	.01
Self-distraction	5.36	1.60	5.55	1.56	5.79	1.76	1.39	.251	.01
Venting	4.60	1.54	4.90	1.75	4.50	1.72	1.31	.271	.01
Humour	4.76	1.89	4.56	1.81	4.27	1.97	1.30	.274	.01
Denial	3.76	1.40	3.63	1.55	3.94	1.69	0.74	.478	.01
Disengagement	3.32	1.31	3.12	1.52	3.19	1.52	0.54	.581	<.01

Note:\*\* $p < .001$ ; \* $p < .05$

## Social Support

Low scores in social support subscales equate to high support. A MANOVA was conducted to ascertain if there were differences on the four social support subscales (Family, Friends, Others, Total score) for the three participant groups (B, S, G). The results of the MANOVA indicated there were significant differences between the three groups on social support measures (Groups B, S, G),  $\Lambda = .95$ ,  $F(6, 554) = 2.51$ ,  $p < .05$ ,  $\eta^2 = .03$ .

Table 16

*Social Support Appraisal Means and Standard Deviations Across Groups*

Scales	Brides		Spouse		Grandmothers	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Family support	14.88	3.85	14.06	3.98	16.04	4.04
Friends support	13.06	3.05	12.73	3.34	14.37	4.36
Others support	15.58	3.31	15.24	3.71	17.48	5.12
Total social support	43.52	9.08	42.04	10.35	47.88	12.81

Table 16 contains the means and the standard deviations of the three social support subscales across the three groups. Follow-up ANOVAs for the groups on each subscale were all significant at  $p < .05$ , Family support,  $F(2, 279) = 4.20$ , Friends support,  $F(2, 279) = 3.99$ , support from Others  $F(2, 279) = 6.22$ , and Total score,  $F(2, 279) = 5.50$ . Post hoc analyses using the univariate ANOVAs consisted of pairwise comparisons to ascertain where the differences between the groups were on social support subscales. Six of the 12 possible comparisons were significant. Four significant comparisons were between grandmothers and the other two groups for support from both Others and Total support; two significant comparisons were between grandmothers and spouses for support from both Family and Friends. No significant difference was noted between the brides and spouses in all social

support scales. Grandmothers reported receiving the least support on all social support scales. In contrast, spouses intramarried to Filipino men reported receiving the highest social support.

To assess the factors that impacted on mental health across each of the three participant groups (B, S, G), and to investigate the stability of these predictors across the three groups, several analyses were performed. First, a correlational analysis was conducted with each group to determine the relationship between each independent variable (acculturation, 4 social support scales, and 14 coping subscales) and the outcome variables (depression, anxiety and stress). Tables 17-19 contain the correlations for each of the groups. Table 17 reports on the correlations between demographic variables, acculturation, social support and coping for the Brides, Table 18 for the Spouses and Table 19 for the Grandmothers. Second, secondary analyses were performed with each group to investigate the contribution of each variable to outcome variables, depression, anxiety and stress respectively. Those variables that significantly predicted the outcome variables are presented in Tables 20 to Table 23. Table 20 shows multivariate results on simple regression on DASS subscales and select variables. Table 21 shows the predictors for the depression and Table 22 for anxiety, and Table 23 for stress.

### **Results of Correlational Analyses with Each Participant Group**

Table 17 shows that for the Brides, there were also strong positive correlations found between the three dimensions of mental health (stress, anxiety, depression). Table 17 also shows that location of residence in Australia was a significant positive correlation with two DASS variables (depression, anxiety). The number of years of residency in Australia had a significantly negative correlation with the depression subscale but not with the other DASS variables. There were no significant correlations found between all DASS variables and age, income, presence of children in Australia, caregiver role and acculturation level.

Table 17

*Variables Correlating with Depression Anxiety Stress for Group B*

	Depression	Anxiety	Stress
<b>Demographic variables</b>			
Age	.02	.12	.06
Income	.089	.03	-.02
Location of residence	.25**	.18**	.06
Years in Australia	-.178*	-.06	-.03
Children in Australia	-.11	-.16	.03
Caregiver role	.07	.06	.09
Acculturation level	-.08	-.12	-.12
<b>DASS subscales</b>			
Depression	1		
Anxiety	.78**	1	
Stress	.71**	.73**	1
<b>Social support subscales</b>			
Social support – family	.20*	.09	.10
Social support – friends	.23**	.13	.11
Social support – others	.22**	.15	.11
Social support – total	.24**	.14	.12
<b>Coping subscales</b>			
Self-distraction	.12	.24**	.23**
Active coping	-.04	.09	.05
Denial	.36**	.36**	.35**
Substance use	.17	.08	.07
Emotional support	.26**	.25**	.29**
Instrumental support	.23**	.28**	.23**
Disengagement	.55**	.50**	.41**
Venting	.28**	.32**	.29**
Positive Reframing	-.07	-.01	-.04
Planning	.05	.12	.19*
Use of humour	.09	.06	.01
Acceptance	.11	.12	.16
Religiosity	.15	.19*	.17*
Self-blame	.34**	.33**	.33**

Note: \*\* Correlation is significant at the 0.01 level (2-tailed)

\* Correlation is significant at the 0.05 level (2-tailed)

For the outcome variable depression, correlational analyses revealed all four social support subscales were significantly positively correlated with depression. Additionally, the coping variables, Disengagement, Self-blame, Denial, Venting, Emotional and Instrumental coping strategies, all showed significant positive correlations with depression.

For the outcome variable anxiety, the coping strategies, Disengagement, Denial, Self-blame, Venting, Instrumental, Emotional, and Self-distraction, all showed significant positive correlations with anxiety.

Finally, for the outcome variable stress, the coping strategies, Disengagement, Denial, Self-blame, Emotional, Venting, Self-distraction, Instrumental, Planning and Religiosity, all showed significant positive correlations with stress. The correlations for the Spouses are presented in Table 18.

Table 18

*Variables Correlating with Depression Anxiety Stress for Group S*

	Depression	Anxiety	Stress
<b>Demographic Variables</b>			
Age	.01	-.02	-.07
Income	.07	<.01	-.02
Location of residence	.08	.13	.14
Years in Australia	-.07	-.13	-.09
Children in Australia	-.09	.02	-.03
Caregiver role	-.19	-.08	-.08
Acculturation level	-.23*	-.20	-.17
<b>DASS subscales</b>			
Depression	1		
Anxiety	.80**	1	
Stress	.86**	.83**	1
<b>Social support subscales</b>			
Social support – family	.17	.21*	.20
Social support – friends	.08	.13	.09
Social support – others	.14	.17	.13
Social support – total	.14	.18	.15
<b>Coping subscales</b>			
Self-distraction	.09	.09	.15
Active coping	-.18	.04	.05
Denial	.46**	.34**	.45**
Substance use	.29**	.27*	.24*
Emotional support	.05	.09	.14
Instrumental support	.14	.11	.23*
Disengagement	.45**	.40**	.48**
Venting	.20	.11	.21*
Positive Reframing	-.08	-.01	-.03
Planning	-.09	-.02	-.03
Use of humour	-.06	-.08	-.05
Acceptance	-.09	-.09	-.06
Religiosity	-.03	-.04	-.02
Self-blame	.41**	.36**	.43**

Note: \*\* Correlation is significant at the 0.01 level (2-tailed)

\* Correlation is significant at the 0.05 level (2-tailed)

Table 18 indicates that for depression, the coping strategy Denial showed the strongest relationship with depression outside of the other DASS variables. Additionally, the coping variables Disengagement, Self-blame and Substance use showed positive correlations with depression. Table 18 also indicates that the acculturation level has negative correlation with depression. All of the subscales of Social support did not show significant correlations with depression.

For the outcome variable anxiety, it was significantly negatively correlated with marital status. There were no significant correlations with other demographic variables and the acculturation level. Meanwhile, the coping strategies, Disengagement, Self-blame, Denial and Substance use all showed significant positive correlations with Anxiety. Of the social support subscales, only Family support showed a significant correlation with anxiety. The coping strategy Disengagement showed the strongest relationship with anxiety outside of the DASS variables.

Finally, for the outcome variable stress, the acculturation level showed significant negative correlation with stress. The coping strategies, Disengagement, Denial, Self-blame, Substance use, Instrumental, and Venting, showed significant positive correlations with stress, with Disengagement showing the strongest relationship. None of the Social support subscales showed significant correlations with stress. The correlations for the Grandmothers are presented in Table 19.

For the outcome variable anxiety, the coping variables, Humour, Venting, Denial, Disengagement, Acceptance, Planning, Instrumental and Self-distraction, all showed significant positive correlations with anxiety. Meanwhile, the variable, social support from Others showed a significant negative correlation with anxiety. Humour showed the strongest relationship outside of the DASS variables. Finally, for the outcome variable Stress, the

coping strategies, Humour, Disengagement, Planning, Venting, Acceptance, Self-blame, Self-distraction, Denial, Instrumental and Reframing, all had significant positive correlations with stress. Humour showed the strongest relationship to stress outside of the other DASS variables.

Table 19

*Variables Correlating with Depression Anxiety Stress for Group G*

	Depression	Anxiety	Stress
<b>Demographic variables</b>			
Age	-.14	-.18	-.12
Income	.02	-.03	.06
Location of residence	-.07	-.06	-.07
Years in Australia	-.02	.02	.13
Children in Australia	.20	.10	.06
Caregiver role	.11	-.07	-.02
Acculturation level	-.15	-.18	-.08
<b>DASS subscales</b>			
Depression	1		
Anxiety	.69**	1	
Stress	.70**	.79**	1
<b>Social support subscales</b>			
Social support – family	.09	-.21	-.18
Social support – friends	.07	-.20	-.23
Social support – others	-.06	-.32*	-.29
Social support – total	.03	-.26	-.25
<b>Coping subscales</b>			
Self-distraction	.28*	.31*	.34*
Active coping	.23	.27	.16
Denial	.36**	.46**	.31*
Substance use	-.09	-.20	-.18
Emotional support	-.15	-.<.01	.06
Instrumental support	.17	.32*	.30*
Disengagement	.34*	.39**	.48**
Venting	.28*	.48**	.39**
Positive Reframing	.14	.34*	.27*
Planning	.13	.33*	.41**
Use of humour	.34*	.51**	.49**
Acceptance	.19	.39**	.37**
Religiosity	.16	.27	.27
Self-blame	.08	.24	.37**

Note: \*\* Correlation is significant at the 0.01 level (2-tailed)

\* Correlation is significant at the 0.05 level (2-tailed)



Further analyses were performed to investigate the contribution of each variable to mental health (depression, anxiety and stress) and to test the stability of predictors across the three groups using simple regression and moderation tests.

### **Predictors of Mental Health Across the Three Participant Groups**

Simple regression analyses were conducted to determine the variables predicting mental health. For example, a simple univariate regression model was used for one continuous predictor, while a simple multivariate regression model was used for one continuous predictor and one categorical predictor. This was followed by moderation test for the variables that showed significant results in the simple regression analyses. To investigate if certain demographic variables (age, education, income, location of residence, years in Australia, children in Australia, caregiver role), acculturation level, coping strategies and social support were predictors of mental health (depression, anxiety, stress), a simple regression was performed with mental health scores (Depression, Anxiety and Stress) as the dependent variables, and coping (Brief-COPE, 14 subscales) and social support (SS-A, 4 subscales) as the independent variables.

Table 20 displays the multivariate results,  $\Lambda$ ,  $DF$ ,  $F$ ,  $p$  and  $\eta^2$  values. The results of multivariate tests in the regression analyses indicated that all types of social support, twelve of the fourteen coping strategies (except for Religiosity & Reframing), and a number of demographic variables (ie. location of residence & education of self) were significant predictors of outcome variables across the three groups. Of all the variables entered in the regression analyses, Disengagement was the highest predictor,  $\Lambda = .76$ ,  $F(3, 278) = 29.99$ ,  $p < .001$ ,  $\eta^2 = .24$ , followed by Denial,  $\Lambda = .83$ ,  $F(3, 278) = 19.70$ ,  $p < .001$ ,  $\eta^2 = .18$ , and Self blame,  $\Lambda = .87$ ,  $F(3, 278) = 14.47$ ,  $p < .001$ ,  $\eta^2 = .14$ .

Table 20

*Multivariate Results on Simple Regression on DASS Subscales and Select Variables*

	$\Lambda$	$DF$	$F$	$P$	$\eta^2$
Disengagement	0.76	3, 278	29.99	<.001	.24
Denial	0.83	3, 278	19.70	<.001	.18
Self blame	0.87	3, 278	14.47	<.001	.14
Venting	0.92	3, 278	8.58	<.001	.09
Self distraction	0.94	3, 278	6.18	<.001	.06
Instrumental support	0.94	3, 278	5.74	.001	.06
Planning	0.94	3, 278	5.60	.001	.06
Social support- total	0.96	3, 278	3.80	.011	.04
Social support - family	0.96	3, 278	3.69	.012	.04
Location of residence	0.96	3, 278	3.18	.013	.04
Social support – friends	0.96	3, 278	3.44	.017	.04
Substance use	0.97	3, 278	3.08	.028	.03
Emotional support	0.97	3, 278	3.05	.029	.03
Active coping	0.97	3, 278	3.00	.031	.03
Acceptance	0.97	3, 278	2.86	.037	.03
Social support – others	0.97	3, 278	2.82	.039	.03
Education of self	0.97	3, 278	2.87	.037	.03
Use of Humor	0.99	3, 278	1.24	.030	.01
Religiosity	0.98	3, 278	2.15	.095	.02
Acculturation level	0.98	3, 278	2.10	.100	.02
Positive Reframing	0.98	3, 278	2.03	.109	.02
Years in Australia	0.98	3, 278	1.50	.216	.02
Education of partner	0.98	3, 278	1.68	.172	.01
Marital status	0.98	6, 554	1.13	.342	.01
Income	0.98	6, 554	1.11	.356	.01
Children in Australia	1.00	3, 278	0.43	.734	.01
Age	1.00	3, 278	0.031	.820	<.01
Caregiver role	1.00	3, 278	0.63	.979	<.01

The results of the tests of between-subjects effects indicating the  $DF$ ,  $F$ ,  $p$  and  $\eta^2$  values for each outcome variable are shown in the following tables: Table 21 for depression, Table 22 for anxiety and Table 23 for stress.

Table 21

*Simple Regression Results on Depression and Select Variables*

	Depression (DASS Depression)			
	<i>DF</i>	<i>F</i>	<i>P</i>	$\eta^2$
Disengagement	1, 280	79.91	<.001	.22
Denial	1, 280	52.11	<.001	.16
Self blame	1, 280	32.38	<.001	.10
Venting	1, 280	16.71	<.001	.07
Instrumental support	1, 280	9.74	.002	.03
Location of residence	1, 280	8.58	.004	.03
Social support - family	1, 280	8.39	.004	.03
Substance use	1, 280	6.85	.009	.02
Social support- total	1, 280	6.71	.010	.02
Education of self	1, 280	6.26	.013	.02
Social support – friends	1, 280	5.19	.023	.02
Self distraction	1, 280	5.12	.024	.02
Social support – others	1, 280	3.82	.052	.01
Use of Humor	1, 280	2.32	.067	.01
Education of partner	1, 280	3.34	.069	.01
Emotional support	1, 280	2.92	.089	.01
Acculturation level	1, 280	2.86	.092	.01
Income	2, 279	2.30	.103	.01
Years in Australia	1, 280	2.55	.111	.01
Acceptance	1, 280	1.02	.129	.01
Religiosity	1, 280	1.65	.200	.01
Marital status	2, 279	0.84	.432	.01
Active coping	1, 280	0.54	.464	<.01
Children in Australia	1, 280	0.33	.564	<.01
Positive Reframing	1, 280	0.28	.599	<.01
Planning	1, 280	0.81	.776	<.01
Caregiver role	1, 280	0.04	.837	<.01
Age	1, 280	0.24	.877	<.01

For outcome variable depression, coping strategies (Disengagement, Denial, Self blame, Venting, Instrumental, Substance use & Self distraction), demographic variables (location of residence & education), and social support subscales (Family and Total support) were found to be significant predictors across the three groups.

Table 22

*Simple Regression Results on Anxiety and Select Variables*

Anxiety (DASS Anxiety)				
	<i>DF</i>	<i>F</i>	<i>P</i>	$\eta^2$
Disengagement	1, 280	65.02	<.001	.19
Denial	1, 280	45.85	<.001	.14
Self blame	1, 280	29.22	<.001	.10
Venting	1, 280	23.43	<.001	.08
Instrumental support	1, 280	14.27	<.001	.05
Self distraction	1, 280	12.19	.001	.04
Acculturation level	1, 280	6.23	.013	.02
Religiosity	1, 280	5.11	.025	.02
Emotional support	1, 280	4.60	.033	.02
Acceptance	1, 280	4.43	.036	.02
Planning	1, 280	3.93	.048	.01
Use of Humor	1, 280	3.72	.055	.01
Location of residence	1, 280	3.16	.077	.01
Income	2, 279	2.13	.121	.01
Active coping	1, 280	1.16	.198	.01
Education of partner	1, 280	1.63	.202	.01
Social support - family	1, 280	1.58	.209	.01
Years in Australia	1, 280	1.57	.212	.01
Education of self	1, 280	1.45	.230	.01
Substance use	1, 280	1.39	.240	.01
Positive Reframing	1, 280	1.30	.255	.01
Social support- total	1, 280	0.78	.378	<.01
Social support – friends	1, 280	0.56	.454	<.01
Age	1, 280	0.22	.636	<.01
Social support – others	1, 280	0.18	.675	<.01
Caregiver role	1, 280	.12	.727	<.01
Children in Australia	1, 280	.07	.795	<.01
Marital status	2, 279	0.06	.943	<.01

For the outcome variable anxiety, coping strategies (Disengagement, Denial, Venting, Instrumental, Self distraction, Religiosity, Emotional, Acceptance & Planning) and acculturation level were found to be significant predictors across the three groups of Filipino women. All demographic variables and social support subscales were not significant predictors of anxiety for the sample in this study.

Table 23

*Simple Regression Results on Stress and Select Variables*

	Stress (DASS Stress)			
	<i>DF</i>	<i>F</i>	<i>P</i>	$\eta^2$
Disengagement	1, 280	70.91	<.001	.20
Denial	1, 280	47.20	<.001	.14
Self blame	1, 280	41.67	<.001	.13
Venting	1, 280	22.12	<.001	.07
Instrumental support	1, 280	16.00	<.001	.05
Self distraction	1, 280	15.61	<.001	.05
Emotional support	1, 280	8.54	.004	.03
Planning	1, 280	7.47	.007	.03
Acceptance	1, 280	5.89	.016	.02
Religiosity	1, 280	4.47	.035	.02
Education of self	1, 280	4.80	.029	.02
Education of partner	1, 280	4.34	.038	.02
Acculturation level	1, 280	3.17	.076	.01
Income	2, 279	2.42	.090	.01
Use of Humor	1, 280	2.58	.109	.01
Social support- total	1, 280	0.51	.135	.01
Social support - family	1, 280	1.83	.177	.01
Location of residence	1, 280	1.48	.225	.01
Substance use	1, 280	1.22	.271	.01
Marital status	2, 279	0.98	.378	.01
Social support – others	1, 280	0.05	.477	<.01
Years in Australia	1, 280	0.19	.660	<.01
Active coping	1, 280	0.17	.683	<.01
Positive Reframing	1, 280	0.16	.692	<.01
Caregiver role	1, 280	0.15	.701	<.01
Social support – friends	1, 280	0.12	.731	<.00
Age	1, 280	0.09	.768	<.00
Children in Australia	1, 280	0.03	.860	<.00

For the outcome variable stress, coping strategies (Disengagement, Denial, Self blame, Venting, Self distraction, Emotional, Planning & Religiosity) and demographic variable education (both self & partner) were found to be significant predictors of stress across the three groups. All social support subscales were not significant predictors of stress for this sample.

### **Moderation Analyses Between Groups and DASS Subscales**

Moderation analyses were conducted using variables that showed significant results with DASS subscales (depression, anxiety and stress) in simple regression analyses. It was expected that there would be noticeable differences between groups. Demographic variables (education of self and partner, location of residence), acculturation level, perceived social support (family, friends, others and total support), and coping strategies (active coping, self distract, denial, substance, emotional, instrumental, disengagement, venting, planning, acceptance, religiosity, and self blame) were entered as moderators to look at relationships between moderators and independent variables. Results showed that of all the variables entered for moderation analyses, only social support was found to be a significant moderator across the three groups, and only for anxiety and stress outcome variables. Of the social support subscales, only Family support was found to be not a significant moderator. Figures 11-15 show that social support was more strongly related to anxiety and stress for some groups than others.

#### **Results from moderation analysis for friendship support.**

Moderation analysis revealed that support from friends was a significant moderator of the multivariate relationship between Group and the two DASS subscales,  $\Lambda = .95$ ,  $F(6, 548) = 2.34$ ,  $p = .025$ ,  $\eta^2 = .03$ ; however, tests of between-subject effects revealed a significant moderating effect for support from friends for the stress subscale only,  $F(2, 276) = 3.09$ ,  $p = .047$ ,  $\eta^2 = .02$  as shown in Figure 11.

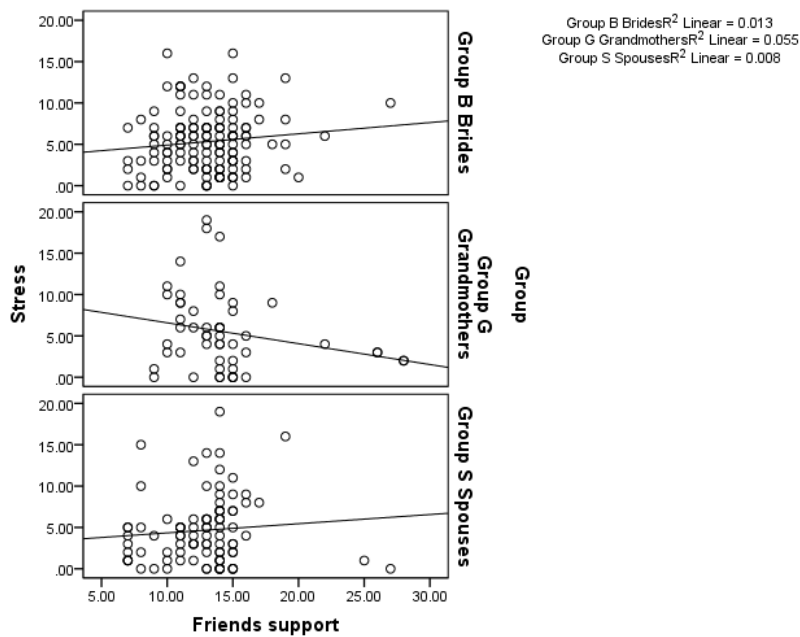


Figure 11. Moderation of relationship between friendship support and stress by group

For Grandmothers, there was a strong negative relationship between stress and social support, indicating that more perceived support from friends is related to a reduction in stress. On the other hand, there is a weak positive relationship with stress and social support for Brides and a very weak positive relationship for Spouses.

#### **Results from moderation analysis for support from others.**

Moderation analysis revealed that support from other people was a significant moderator of the multivariate relationship between Group and the two DASS subscales,  $\Lambda = .94$ ,  $F(6, 548) = 2.69$ ,  $p = .014$ ,  $\eta^2 = .03$ ; however, tests of between-subjects effects revealed significant moderating effect for support from other people for the anxiety subscale,  $F(2, 276) = 6.48$ ,  $p = .002$ ,  $\eta^2 = .05$  as shown in Figure 12; and for stress subscale,  $F(2, 276) = 4.63$ ,  $p = .011$ ,  $\eta^2 = .03$  as shown in Figure 13.

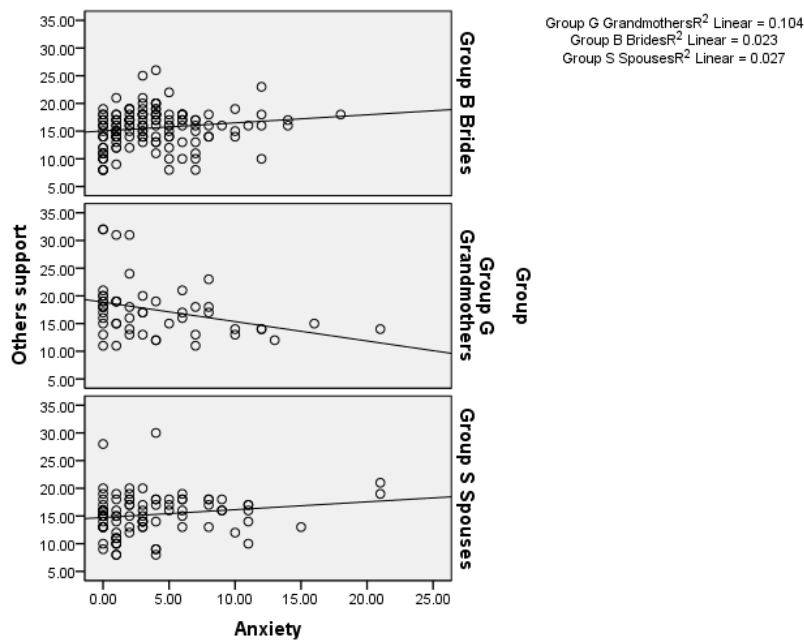


Figure 12. Moderation of relationship between support from others and anxiety group

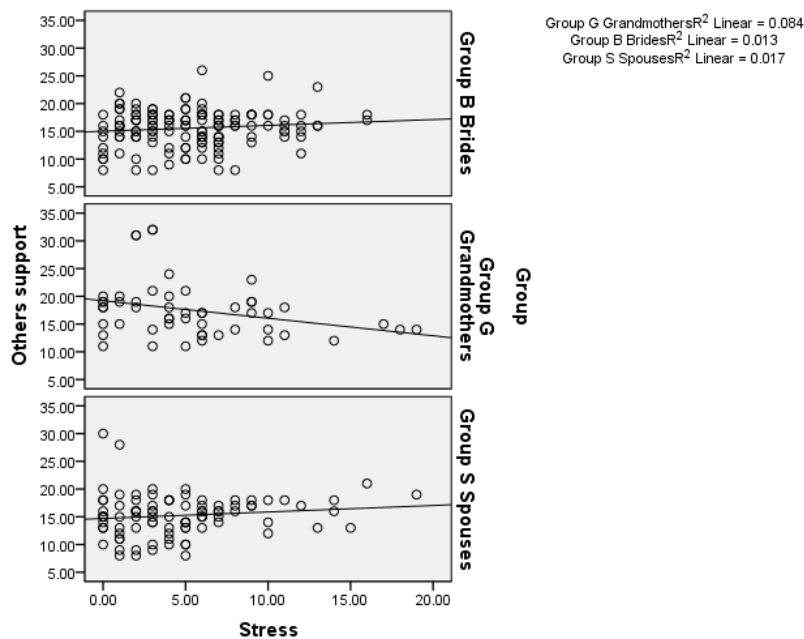


Figure 13. Moderation of relationship between support from others and stress by group

For Grandmothers, there is a very strong negative relationship with anxiety and social support, while a strong negative relationship with stress and social support, indicating that less perceived support from other people is related to a reduction in anxiety and stress.



### Results from moderation analysis for total support.

Moderation analysis indicate that total scores on the support scale (Total support) was a significant moderator of the multivariate relationship between Group and the two DASS subscales,  $\Lambda = .94$ ,  $F(6, 548) = 2.85$ ,  $p = .010$ ,  $\eta^2 = .03$ ; however, tests of between-subjects effects revealed significant moderating effect for total support for anxiety subscale,  $F(2, 276) = 5.03$ ,  $p = .007$ ,  $\eta^2 = .04$  as shown in Figure 14; and for stress subscale,  $F(2, 276) = 4.16$ ,  $p = .017$ ,  $\eta^2 = .03$  as shown in Figure 15.

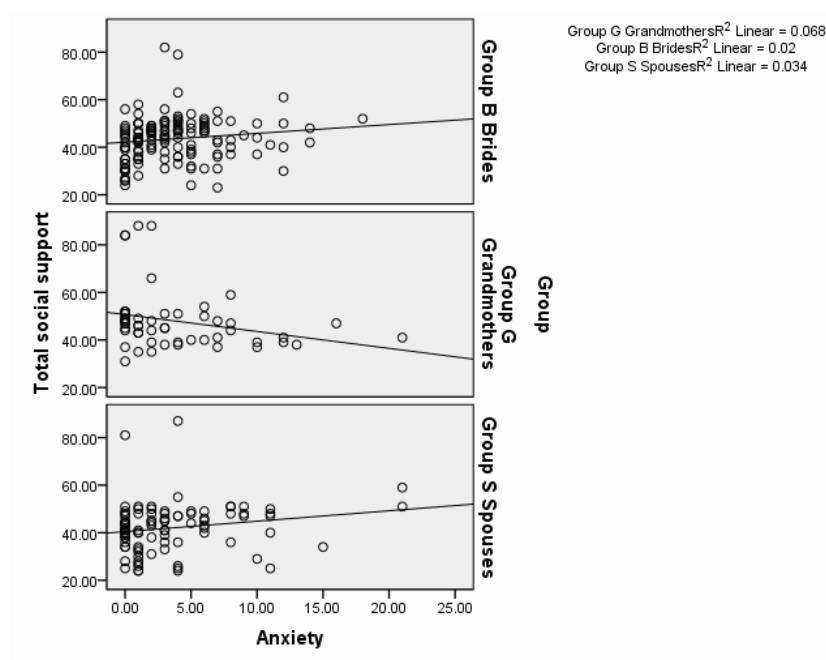


Figure 14. Moderation of relationship between total support scores and anxiety by group

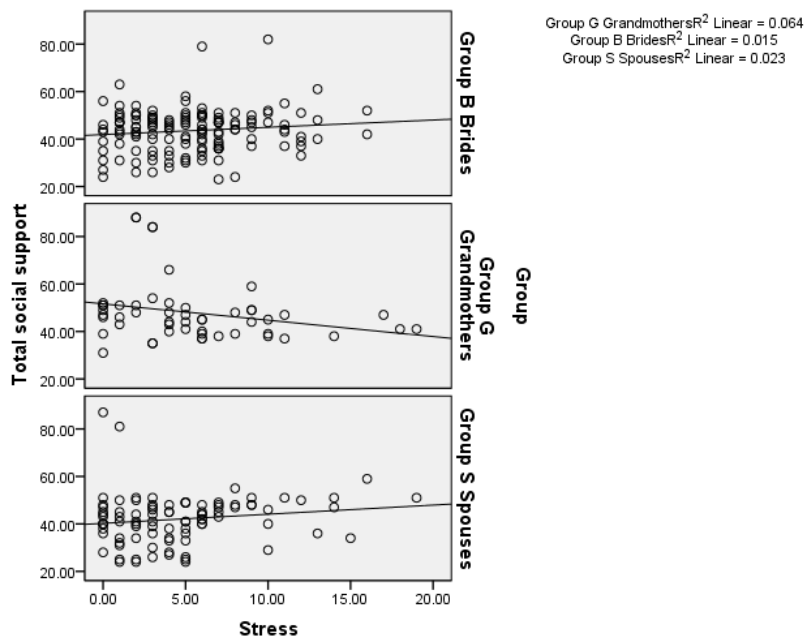


Figure 15. Moderation of relationship between total support scores and stress by group

For Grandmothers, social support had a strong negative relationship with both anxiety and stress with social support, indicating that higher total support is related to a reduction in anxiety and stress. There was a weak positive relationship with anxiety and stress with total support for Brides and Spouses.

At the end of the national survey in Stage 2, in-depth follow-up interviews with eight intermarried women were conducted in order to gather a more meaningful picture of the intermarried brides' migration experience and the nature of their marital relationships. The qualitative data gathered from the eight women lend support to the quantitative results as discussed above. The summary of the interviews are presented in the next section of this chapter.

## **Qualitative Results from Interviews Examining the Intercultural Marriages of Eight Filipino Brides**

Qualitative interviews were conducted with eight intermarried Filipino women in order to gather a more meaningful picture of the intermarried bride's migration experience (Green & Thorogood, 2009; Paterson & Britten, 2008; Mio et al., 2006). These follow-up interviews focused specifically on the nature of the marital relationships. These questions were adapted from research on Canadian research on Filipino marriages (PWCBC, 2000). Eight Filipino women were chosen based on their expressed agreement to participate an in-depth interview at the end of the survey.

Using thematic analysis, the text was inductively coded into concise themes that summarise the key elements within the respondents' accounts (Green & Thorogood, 2009). Extensive verbatim quotes are used in this section of the current study to show the salient issues confronting the eight Filipino women who agreed to participate in a follow-up interview.

### **The Filipino brides.**

The researcher conducted second in-depth interviews with eight Filipino women married to non-Filipino Australian men for the purposes of further investigating their intercultural marriages (Appendix K). The age of the women ranged from 47 to 58 years. The women arrived in Australia between 1974 and 1987. One woman arrived as a single professional, three arrived as brides, and four as fiancées to Australian men. Five of the women were residing in urban areas, while the other three resided in regional areas. One woman was a widow while the remaining women had never been married before their arrival to Australia. The woman reported being married to the Australian husbands between 9 to 30 years. With regard to ages of the couples, the age difference between the women and their

husbands ranged from 1 year to 29 years, with five of the women reporting a 10 to 15 year age difference. In all couples, the men were older than their female spouses.

Apart from one woman with vocational qualifications, all the other women had higher degrees and had worked in professional occupations (eg. Lecturer, Teacher, Dietitian, Office Manager, or Administrator.) In regards to current employment, one woman reported being the primary carer for her husband, while six women reported working in welfare and administrative jobs, while one reported she had recently retired. When asked about their overall health, four of the women reported their health to be “*excellent*”, while four rated their health as “*good*,” despite having difficulties with blood pressure and cholesterol. One of these women reported having recently a mastectomy while her husband was in remission from prostate cancer, and yet when asked about health replied: “*We consider ourselves so blessed and terribly lucky. We have so much to be thankful for.*”

#### **The Australian husbands.**

Four of the Australian husbands were migrants from Europe (Croatia, Italy, Malta, Slovenia) and did not have other relatives in Australia. The men’s age ranged from 61-82 years. Three of the eight men were previously married. In regards to educational attainment, three men had completed university degree, three completed secondary education, while one had completed primary schooling. Two men were currently working as engineers, another two worked in administration, while the remaining four were employed in the trade industry. Four women rated their husband’s health as “*fair*” because of medical problems (e.g. asthma, diabetes, high blood pressure, cholesterol). The other four women reported their husband’s health as “*not good*” with one husband recently diagnosed with prostate cancer.

#### **How the couples met.**

Six of the Filipino women met their husband through friends and cousins. The other two women met their husband at work. When asked what made them decide to marry a

foreigner/Australian, seven women reported *“Their love for a good man from a good country just developed”*. One woman added that it was “also about time for her to get married”. A Filipina woman reported not being happy with a previous relationship with Filipino man made her decide to marry a non-Filipino man. On the other hand, the eight women believed that their husband’s decision to marry a Filipino woman was influenced by *“tell-tale that Filipino woman is amiable, patient, kind and devoted to husband.”* They believed that their *“husband fell in love with them.”* One respondent said her *“husband was not happy with his previous relationship”* with an Australian partner.

Three of the women knew their husband less than a year before they got married, while it was about 2 years for the other five women. They corresponded by telephone and letters. Three of the women visited Australia before engagement or marriage to their husband, while six of the non-Filipino men visited them in the Philippines beforehand. Three of the men have been previously married to a non-Filipino while the other men had never married.

#### **The women’s ideas regarding marriage.**

All women strongly believed that marriage was a commitment with a responsibility to work in partnership with their husband to make the marriage work. One stated, *“In the Philippines, getting married means that you become a couple and everything is shared.”* One woman considered *“marriage as a sacrament and a commitment between two people that is blessed and sealed by a priest.”* The women considered values of love, respect, trust, honesty, patience, openness, communication, financial and physical support, understanding and tolerance of each others’ culture to be an important element of a good marriage. They said there should be mutual respect and cultural awareness.

Three women said their families were optimistic about their marriage to an Australian man, while four of the women said their families had mixed feelings or concerns about their relationship with a foreigner because of the *“unknown”* or *“moving to a foreign country and*

*different culture*". One family was concerned with the age difference between the Filipina woman and the Australian man. However, all reported their families were supportive of their decision to marry an Australian man. Five women got married in Australia (3 urban, 2 regional), while the remaining three were married in the Philippines.

### **Perceptions of life in Australia.**

All eight women reported that their life in Australia was "*good*" and "*easy*", but "*I have to do everything*". For example, all women reported they have to do all the housework while in the Philippines they would have been able to have a housemaid to do their laundry, cleaning or cooking. A woman living in urban Melbourne acknowledged the personal growth for her, saying, "*I learnt to be independent and there's a lot of opportunities.*" However, the women residing in regional areas, in particular, found their new home to be "*too quiet*." One said, "*I felt isolated on the farm.*"

All eight women reported having reservations about migration. For example, they recalled being concerned about getting a job, having no family support, feeling homesick or loneliness, the language differences, and questioning whether the intercultural marriage would work. Five of the women reported that despite Australia not being as popular a migration destination as the USA, they perceived that "*Australia is a land of opportunities and a better place to bring up children.*" One woman said, "*I love Australia for its multiculturalism,*" while another woman declared, "*I never see myself as a coloured person. I know a lot of stuff. I am experienced. I am not afraid to share my experience. There's equality here. My boss, we're a team.*"

All of the women wanted to have children but two women did not have children. One woman who did not have children said, "*Having children would make no difference for me.*" The other woman thought, "*I had a miscarriage. I would be less lonely if I had a child but*

*that meant I would also be caring for them as well as my ageing husband. That would make my carer role more difficult.”*

Five women considered the start of their relationship with their husband as a “*beautiful*” or “*fantastic*” period in their lives. One woman described her husband as, “*He gives me freedom to do things, talk in my own language without being upset. He allows me to meet other Filipinas and drives me to meet them.*” However, two women reported it was “*chaotic*” because of their husband’s “*lack of awareness of other cultures.*” The main points of disagreements or tensions between the couples were differences in expectations about marriage, culture, lifestyle and roles at home. For example, one woman reported that her first disagreement with her husband was to do with money. She reported that initially her Australian husband kept her wage and gave her an allowance. She said, “*In the Philippines it is different...the woman holds the purse strings. I found it insulting. I talked to him and he allowed me to hold the purse.*” Another woman’s experience was similar, “*One tension that came is my husband’s individualism. In (his) their view, you remain separate and getting married seemed like somebody to share in paying bills.*” For a few women, the husband’s excessive drinking was an additional cause for disagreement. However, only two told their families in the Philippines about their problems and found their families very supportive of them. Those who did not tell said that their families had bigger problems and that the matter was not serious. At time of this research interview, six women reported having happy marriages. One childless woman was happily married for 30 years. One woman recently became a widow after caring for her husband who died of cancer. Two women were already separated, for one because of alcoholic and abusive husband, the other woman said they fell out of love but she still cares for him because he does not have other relatives. All women get along well with their husbands relatives in Australia or overseas.

All women got support from friends who were mostly Filipino women they met in community clubs or church. The friends of one woman who migrated as a single professional but met her Australian husband at work became her husband's friends too and have been able to maintain their friendships since late 1970s. Most women also accessed government and non-government services for support. They get help (financial and social support) from government, but they also "*give back by doing volunteer work in the community,*" including helping elderly Filipinos and cultural dances at festivals. All women met other Filipinos in Australia at shopping centres, parties and through other friends. Five women also met Filipinos at work or through their husbands who have made friends with some Filipino migrants before their Filipina wife arrived in Australia. Seven women found most Filipinos were supportive of their marriage to an Australian, but they also found that "*a few others were just curious.*"

All women said they wanted to work in Australia. Six women were working. Two women were not working; one was a full time mother and carer of ill husband, the other woman just retired and was doing voluntary work. Of the six women working, three women were performing social or welfare work, three were in administrative work. A woman said work is easier for her in Australia "*because they respect your skills here. I assimilate with people at work.*" All women said most income goes towards everyday living expenses.

All women worked in the Philippines and held positions like Lecturer/Teacher, Dietitian, Secretary, Administrator, Manager or Dressmaker. Most women said they were able to support themselves and their families' everyday living expenses. One woman was financially independent because of her business. Most women were from middle class families.

Most women occasionally send money to the Philippines to help relatives with education or health expenses. Sometimes they send money to buy electronic items e.g.



television. One woman said it was the opposite for her. Her families in the Philippines often send money to her in Australia to help her instead of her sending money over there. Most women had plans to sponsor relatives to migrate to Australia. But three women said more stringent migration requirements (e.g. educational level, work experience or skill set, age) might make it difficult for their relatives to qualify to migrate to Australia.

## **Summary of Stage 2**

Study 2 was designed to examine the relationship between migration circumstances (migration for marriage or to help family), acculturation experiences, caregiving roles, psychological resources (e.g. age, education, marital status, education), social resources (e.g. income, regional/urban, family ties, social support), coping strategies and mental health of the overseas-born Filipino women (brides, spouses, grandmothers) dispersed in urban, rural and remote areas of Australia. It was also envisioned that the follow-up interviews of eight Filipino women would highlight the nature of intercultural marriages and elements of positive ageing of Filipino brides in Victoria, Australia.

The results of various statistical analyses of the data collected from the national survey conducted in Stage 2 showed significant group differences in demographic profiles, acculturation level, coping strategies, perceived social support and mental health.

Brides married to non-Filipino Australian men reported the highest levels of acculturation, while the elderly grandmothers reported the lowest levels of acculturation, indicating brides had a more Australian disposition than Filipino spouses and grandmothers who were married to Filipino men.

For coping strategies, there were significant differences across the three groups, with emotional support had the strongest significant effect, followed by more positive or active coping strategies like positive reframing, religion, instrumental support, active-coping and planning. There were also significant correlational differences with DASS subscales across the three groups, with disengagement showing the strongest significant relationship with most of DASS subscales across the groups. These results were supported by subsequent simple regression analyses. The results of multivariate tests in the regression analyses indicated that nearly all of the coping strategies (except for religiosity & reframing) were significant

predictors of outcome variables across the three groups, with disengagement as the highest predictor, followed by denial, and self blame.

For social support, the results showed significant differences between grandmothers and the two other two groups on both social support from other people and total support, and between grandmothers and spouses on support from family and friends. There were no significant differences between brides and spouses in all social support scales. Grandmothers reported receiving the least support on all social support scales. In contrast, spouses reported receiving the highest social support, with social support from family. For brides, all social support subscales were significantly positively correlated with depression, as well as social support from friends and other people with overall mental health.

The result of simple regression tests showed Social support as a strong predictor of anxiety, stress and mental health but only for grandmothers. Social support was not a significant predictor of anxiety, stress and mental health for both brides and spouses. There was a weak positive relationship with anxiety, stress and mental health and social support for both brides and spouses. Social support was the only significant moderator of the relationship between groups on anxiety, stress and mental health and only for grandmothers.

The results of the quantitative analyses for the brides were supported by the qualitative data collected from follow-up interviews of eight of Filipino women married to non-Filipino Australian men residing in both urban and regional areas of Victoria, Australia.

## **Chapter 8: Discussion**

### **Background to the Study**

Much research has been conducted in Australia documenting the needs and challenges of migrant community groups. However, there is a paucity of research on the Filipino community in Australia. This community is important to investigate, given that individuals of Filipino background are predicted to become the sixth largest cultural group in Australia by 2026. In addition, migration to Australia for marriage has also featured prominently for this cultural group, particularly during the 1980s. Around the same time of intermarriage migration by Filipino women in 1980s, two other groups of Filipino women migrated to Australia – firstly either as young spouses of Filipino men or alternatively as old grandmothers to care for their grandchildren in Australia. Thus, migration for marriage and family reunification were major factors resulting in the gender imbalance of this cultural group in Australia. These unique features of the Filipino migrant community highlighted the need to further investigate both the mental health and health and service utilization of this cultural group in Australia.

A review of the limited literature on Filipino migration in Australia has highlighted that, not unlike many women from other cultural backgrounds (Jirojwong & Manderson, 2001), many older Filipino women manage multiple roles as wife, mother, grandmother, daughter, sister, and caregiver for a kin while also approaching old age (D’Mello & Esmaquel, 1990; San Jose, 1995). However, what distinguishes Filipino women from many of the other immigrant women is their pattern of migration and settlement experiences in Australia. What also remains unclear is the mental health and health service utilisation of each of these three groups of women. Thus, the Filipino women who participated in the current study were grouped according to their reasons for migration: first, brides intramarried

to non-Filipino men; second, spouses intermarried to Filipino men; and third, grandmothers who migrated in old age to look after grandchildren in Australia. The theoretical model adopted in the current study was Wong's (1993) resource-congruence model of adaptation based on Asian elderly migrants (Wong & Ujimoto, 1998). This model posits that coping efficacy depends on sufficient coping resources, multicultural competencies, and the selection of coping goals and responses that are appropriate to the situation and cultural context (Wong, Wong et al., 2006). Using this model of coping, the current study investigated the relationship between migration circumstances, acculturation experiences, social roles (caregiver, non-caregiver), coping strategies, mental health and health service utilization by Filipino women who migrated to Australia under different circumstances.

The current study adopted a combination of qualitative and quantitative methodologies for data collection, as this combination is recommended when conducting cross cultural research (Bryman, 2006). This method was also enhanced by methodologies based on indigenous Filipino psychology (Enriquez, 1993; Gonzales, 1995; Mio et al., 2006; Torres, 1995). The researcher interviewed community leaders and Philippine-born Filipino women living in Victoria in Stage 1, while Stage 2 comprised of questionnaires and interviews with Philippine-born Filipino women recruited across five Australian states. The Victorian and national survey quantified the issues older Filipino migrant women were facing and the personal and socio-environmental resources they utilised as they settled and aged in Australia. These resources included age, education, location of residence, caregiving role, social support, psychological health, use of health and information services, and coping strategies used to adapt to the challenges. The qualitative interviews gathered textual descriptions of people's experiences, beliefs, views, emotions, and relationships relating to their settlement and ageing in Australia. Overall results indicated that the research design

used in the current study (i.e. cross-sectional survey supplemented by qualitative interviews and purposive sampling) captured the subtleties and nuances of the Filipino culture.

### **Findings of the Study**

The results of the current study supported the hypotheses that there would be differences across the three groups of Filipino women on acculturation, coping strategies, perceived social support, and mental health.

The results supported the hypothesis that Filipino women married to non-Filipino Australian men demonstrated higher levels of acculturation and higher levels of mental health and social support from friends and others. Further, the results also supported the hypothesis that older Filipino women who migrated at advanced age nearing or after retirement age to look after the grandchildren displayed lower levels of acculturation and higher maintenance of ethnic identity than intermarried brides and intramarried spouses. However, the hypothesis that women in caregiving role would report lower mental health compared to non-caregivers was not supported in the current study. In addition, the findings highlighted the pivotal role of social support in the positive ageing of older Filipino women in Australia.

The results of the current study showed that there were significant variations in mental health across the three groups, as well as differences in education, location of residence (urban/regional), acculturation level, perceived social support, and coping strategies. Specifically, education, location of residency, acculturation, social support and coping strategies significantly correlated with mental health. Regression analyses indicated that all types of social support, twelve of the fourteen coping strategies, and a number of demographic variables (i.e., location of residence & education of self) were significant predictors of mental health across the three groups. Disengaged coping was the highest predictor of mental health, followed by denial, and self-blame, while social support was the

only significant moderator of mental health, but only for grandmothers and not for the other two groups of women.

For brides married to non-Filipino Australian men, results indicated that brides experienced depression in early years of settlement, but that their depression decreased with length of residency in Australia. The brides living in regional areas of Australia experienced lower mental health compared to their urban counterparts. Brides tended to seek more social support from others and friends than their family. This may be explained by the limited number of family members available in Australia, as most brides reported their relatives resided back home in the Philippines. Also, brides tended to use avoidant or emotional coping strategies (disengagement, denial, self-blame, venting, emotional, instrumental, self-distraction and religiosity) to cope with depression, anxiety and stress, and to achieve better mental health. Interestingly, the brides' age, income, presence of children in Australia, caregiver role, and acculturation levels did not significantly influence their mental health. Follow up interviews with the eight brides also showed some used gambling, alcohol, and an avoidant coping style such as disengagement, denial, and self-distraction to cope with their challenges.

For Filipino spouses married to Filipino men, stress had the strongest impact on their mental health. Spouses with lower acculturation levels reported higher levels of depression and lower mental health. Conversely, those spouses who received social support from their family reported enhanced mental health. Interestingly, spouses tended to use avoidant and emotional styles of coping (such as disengagement, denial, self-blame, substance use and self-distraction) to improve their mental health.

Grandmothers reported a preference for problem solving or cognitive oriented coping strategies which was shown to enhance their mental health. Specifically, the use of humour by this group showed the strongest influence on mental health. Grandmothers also tended to

use acceptance, planning, instrumental and reframing coping, and less venting, denial, and self-distraction to maintain their mental health. Social support from family, friends and other people also influenced the grandmothers' mental health.

Previous research on other cultural groups has shown that older migrants who originated from urban areas experience better psychological health than those who come from rural areas (Thomas, 1999). In the current study, with the exception of brides, the majority of the Filipino women were born in urban areas in the Philippines and settled in urban areas in Australia. However, brides in urban areas reported more positive experiences compared to those in regional areas, while grandmothers described their settlement period as characterised by more negative than positive experiences. This variation might suggest that adjusting to urban life in Australia might have been an additional stressor to migration for grandmothers and might be partly explained by acculturation level. Brides and younger participants also showed higher acculturation while grandmothers and older participants showed a stronger sense of belonging with the Filipino community and lower acculturation levels. Brides married to non-Filipino Australian men reported the highest levels of acculturation, while the elderly grandmothers reported the lowest levels of acculturation, indicating brides had a more Australian disposition than Filipino spouses and grandmothers who were married to Filipino men.

Simple regression and moderation tests were performed to investigate the contribution of each variable to overall mental health and to test the stability of predictors across the three groups. The simple regression tests showed that education of self, location of residence, acculturation level, social support, and coping strategies disengagement, denial, self-blame, venting, instrumental, self-distraction, emotional, religiosity & acceptance were significant predictors of overall mental health across the three groups. The moderation tests showed that social support was the only significant moderator of mental health. Social support from



friends and other people had a significant moderating effect, but only for grandmothers. For the Filipino women in the current study, social support and personal resources might have compensated for their inability to choose their roles (e.g. caregiving role), hence moderated the impact of demands placed on their mental health.

Overall, the Filipino women in the current study reported positive wellbeing. The combined results of qualitative and quantitative investigations indicated support for Wong's resource congruence model of adaptation for older Asians. The Filipino women in the current study reported personal resources (Filipino cultural values of filial love, respect and duty, indebted gratitude and family centredness, education, language skills, age, reason for migration, settlement location, acculturation level, varied coping strategies) and socio-environmental resources (such as social support from friends and other people through ethnic clubs or religious associations or formal health and social support services associations) that contributed significantly to reducing stress, restoring balance and enhancing positive mental health of brides, spouses and grandmothers. However, informal resources were utilised before formal community resources.

The current study showed that specific factors at group and individual levels affected the process of acculturation and adaption to stress and ageing. These factors included personal resources as well as social resources. The availability of these resources, together with socio-demographic characteristics such as age, gender, and education influenced the Filipino women's settlement experience and mental health.

Results of the current study supported the literature indicating that it is not the number of activities but the lack of support (Thompson et al., 2002) and the inability to choose one's roles and organise one's resources to meet the demands that places a burden on women's wellbeing (McGoldrick, 2003). For grandmothers specifically, although they reported receiving the least social support, the Filipino grandmothers showed proactive coping in

accessing support from friends and other people that was congruent with their needs and thereby compensated for what was lacking (Wong, 1993; Wong, Wong et al., 2006).

In addition, the results reinforced the argument that intergenerational exchange is supported by gender and marital status (Kendig, 1986) and influenced by the size of each generation and their cohort characteristics, perceptions, culture and attitudes, family status, cohesions and structure (Millward, 1998), economic ties, living arrangements and length of residency in the new country (Glick & Van Hook, 2002; Hugo & Thomas, 2002) and historical forces (Becker et al., 2000). The exchange through caregiving lead to growth, meaning and integration of values, roles and strengths with a new identity (Jones et al., 2002), enhanced family relationships and greater sense of purpose in life (Burke et al., 2004). This current study also highlighted the results of previous studies that social support had a huge effect on the wellbeing (Moos & Moos, 1987; Thompson et al., 2002) and adjustment of the older migrants (Thomas & Balnaves, 1993).

The findings in the current study were contrary to previous literature that found that although receiving formal and informal supports, older Asian migrants reported higher levels of distress (Chou, 2007) because of linguistic factors (Thomas, 2003) and marital status change to widowhood or divorce (Bennett, 2006), but similar to other studies that found that for some women who occupied multiple roles they reported higher life satisfaction and lower depressive symptoms (Barnett, 2004) and that social ties with family and friends acted as enablers for older women to engage in social and physical activities (Browning & Kendig, 2010), and as moderator of the mental health of the older Filipino women who did not have children (Wu & Hart, 2002).

The current study supported literature on predictors of psychological health in older adults (Fiske et al., 2009), particularly for the Asian elderly (Wong & Ujimoto, 1998). The findings highlighted that Filipino women who had more personal and environmental

resources relied more on active coping than avoidance coping and reported positive mental health. Personal resources such as age, levels of education, the ability to speak English and the length of residence were important indicators of wellbeing for migrants (Minas & Hayes, 1994; Thomas & Balnaves, 1993; Tran, 1987; Wong, 1993; Wong & Ujimoto, 1998; Wong, Wong et al., 2006).

The current study supported the theoretical model of Wong (1993) proposing that successful adaptation starts with development of various types of personal resources and moves through the process in anticipation of potential problems or stressors. This shift was called proactive coping in contrast to typical reactive coping as demonstrated particularly by the grandmothers in this study. Development of resources came from learning from experience and consideration of available options; relating by making friends, networks, building communities, helping others; and increasing inner resources, such as psychological and spiritual health. The results of the current study suggested that the efficacy of coping have been influenced by sufficiency of the coping resources, that included multicultural competencies, and the selection of coping goals and strategies that were appropriate to the situation and the cultural context.

## **Implications of the Study**

The limited literature on Filipino migrants in Australia had focused mainly on intercultural marriage and grandparenting. The current study was conducted across five Australian states and included the Filipino women married to Filipino men. Thus, the current study provided the Filipino community valuable information on the association between migration patterns, caregiving experience (as grandparent, spouse or adult child), mental health and service utilisation of all groups of Filipino female migrants. The results also contributed to the framework of a culturally sensitive model of health care for older Filipino female migrants particularly older Filipino women in Victoria. The results of this project informed the community linkage partner's proposed model of positive ageing for this predominately female community who are dispersed in both urban and regional areas. By including a sample of participants living in isolated rural and regional towns, the project added important data on social and environmental determinants of health and wellbeing among cultural groups in regional and urban areas.

The progressive findings from the current study assisted the community partner in the study in designing a Filipino model of strategic aged care program and was the first Filipino association to successfully receive recurrent funding for a total of 20 aged care packages for metropolitan Melbourne. The senior community leader conducted seminars and workshops with the researcher in order to assist other Filipino associations in designing models of care for Filipino migrant communities across Australia. The project was valuable in the promotion of mental health of older migrant women who came to Australia under special circumstances, which still apply to other groups of migrant women today.

## **Challenges and Limitations of the Study**

Conducting cross-cultural research such as the current study also involved several challenges. Although the main researcher was from the same cultural and linguistic background as the convenient sample, there were also challenges confronted that were inherent in cross-cultural research. The primary challenges included: 1) Access to ethnic women in intermarriage; 2) Access to women in rural and remote areas; 3) Definition of old age; 4) Integration of qualitative or indigenous psychology and quantitative methods; 5) Active engagement of community in research process; 6) Development of culturally sensitive assessment measures & methods of obtaining data; and 7) Balancing between needs/demands of linkage community partner and academic requirements and avoid sacrificing the needs and interests of researcher. These challenges were addressed through research design being informed by literature on effectively combining qualitative, quantitative and indigenous psychology in cross-cultural research on migrants.

Owen (2001) described five advantages of utilising the focus group format with vulnerable groups, which may be relevant to older migrant participants. First, focus groups rely on verbal communication and therefore do not discriminate against people who cannot read or write. Second, because the focus group setting provides a friendly, comfortable and inviting environment, the focus group can encourage people to share their thoughts and experiences when they would otherwise be reluctant to be interviewed on their own. Third, because the group interaction is promoted over interaction with the facilitator, this gives participants greater control over the direction of the discussion and allows for a richer exploration of the issues from the participants' perspective. Fourth, the focus group promotes a respectful, non-condescending atmosphere by respecting the views brought forward by all group members. And finally, the focus group is generally an enjoyable experience because of its friendly atmosphere. Owen (2001) also noted that focus groups may be particularly suited

for female participants because of their established tradition of sharing personal information with other women. Ekblad and Baarnhielm (2002) also argued that focus groups are more conducive to stimulating discussions than individual interviews, and thus results obtained through focus groups have higher face validity.

As with any data collection method, however, focus groups also contain certain inherent disadvantages. For example, ethical issues related to privacy and confidentiality are raised because information disclosed is heard by all participants. The presence of dominant group participants may influence the level of disclosure by other participants and thus produce results that are not representative of the group's experiences and perspectives. The facilitator's level of experience can also influence results. Examples of these influences include how competently the facilitator directs the session, how effectively the facilitator monitors and responds to verbal and non-verbal responses, and how any conflict that may arise is managed by the facilitator (Halcomb et al., 2007). Nevertheless, many limitations can be partially or wholly overcome by careful planning and training.

The study was cross-sectional and correlational design, hence, no comments can be made about causation but only about the association between variables. The other limitations of the current study included generalisability due to purposive sampling, potential cultural or cohort bias (for example widow bias), self-report measures, and the exclusion of physical health or general health measures because the questionnaires were already too long with the inclusion of the questions strongly endorsed by the community linkage partner. With regards to psychological symptoms within the design of the study, the participants' cultural values, for example to save face or maintain social status in the community, may have influenced their self-report.

The study also suggests the usefulness of different methodologies and theoretical frameworks based primarily on indigenous Filipino psychology (Enriquez, 1993; Gonzales,

1995; Mio et al., 2006; Torres, 1995). The different methodologies and frameworks assisted in identifying the important stress and coping differences between the three groups of Filipino women (intermarried brides, intramarried spouses, grandmothers) of different migration patterns to Australia.

Given the limited empirical literature on the Filipino migrants in Australia and the results of the current study on Filipino women, the current study poses a challenge to conduct a study on older Filipino men as many migrated to Australia under assisted skilled migration in 1970s and more recently to fill labour shortages in Australia. Another opportunity for research is the group of grandchildren that the grandmothers looked after and to explore intergenerational differences between age, gender and migration group cohorts. A future challenge for policy makers, funding agencies and service providers is to develop interventions that are responsive to specific individual and community characteristics that may impact the treatment plan.

## **Conclusions**

The strength of the study was that it contributed to the limited literature on predictors and moderators of positive mental health of older Filipino women migrants in Australia and not just on Filipino women in inter-cultural marriages. The best predictor and moderator of mental health was social support, particularly for Filipino grandmothers who migrated in old age. The findings support vast literature that indicates perceived social support moderates the effect of stressful events in older adults. Commonly depression is less prevalent in older adults compared to younger adults, however the consequences of depression in older adults may be critical. For the Filipino women in the current study, all reported positive mental health with reported levels of depression, anxiety and stress below the population means. This result may be explained by the moderating factors in the current study. The vast literature on psychological and social factors that moderate or buffer against depression

emphasised the importance of resources (health, cognitive function, socioeconomic status), psychological strategies and ways to utilise social support to manage health related stresses learnt from life experiences, and meaningful engagement in activities. Social support may be helpful to encourage people, particularly older migrants, to engage in meaningful activities that may include involvement in social activities, volunteer work or religion that may also reduce the risk of depression in older adults. Majority of the Filipino women in the current study, including those living in regional areas of Australia, were engaged in some for activity with ethno-specific associations, social clubs, or religious groups in various capacities, for example as a volunteer worker or community leader or as a singer in a church choir. Literature also indicate that experiencing negative affects also declines with age, thus compared to younger adults, older adults tend to be less reactive to stressors particularly interpersonal interactions. The older Filipino women in the current study tended to focus on positive and emotionally meaningful experiences than younger women, this suggested better emotion regulation with ageing.

The results of the current study may inform the Filipino community organisations and mainstream services in planning for newly arrived migrant women about the importance of providing support to family and ethnic community resources in facilitating positive adjustment to both migration and ageing of the individual migrant. The positive adjustment may be influenced by historical, cultural, social, familial, gender and religious factors that mental health practitioners needed to consider when working with migrant women from diverse cultures.



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# MEMORANDUM



**FROM:** Lina Papillo, Secretary, SET Portfolio Human Research Ethics Sub-Committee (Non-Biomedical)  
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**TO:** Ms Antonietta Butler-Wilks, School of Health Sciences  
**DATE:** 10 March 2005  
**RE:** Application for ethics approval  
**CC:** Professor Trang Thomas, School of Health Sciences; Dr John Reece, Chair, SET Portfolio Human Research Ethics Sub-Committee (Non-Biomedical)

Some required changes to your application for ethics approval for your project titled, *Brides and Grandmothers: Challenges for Older Filipinos in Australia*, were brought to your attention in my memo to you of 1 February 2005. You have addressed all of the issues raised in that memo appropriately. Therefore, you may consider your project, as it is described in your revised application, **APPROVED** for a period of three years from the date on this memo.

Please note the following information, which pertains to all HREC approved projects:

- Projects are normally approved for a period of three years from the date of this letter, but this is conditional on the receipt of annual reports. If your work is completed within twelve months a final report, only, is required. The relevant forms are available from the Human Research Ethics Committee web site. The address for this site is: <http://www.rmit.edu.au/council/hrec>.
- If, as you proceed with your investigation you find reason to amend your research method, you should advise the Chair of the RMIT University Human Research Ethics Committee (Portfolio of Science, Engineering and Technology Sub-Committee (Non-Biomedical) and seek approval of the proposed changes. If you decide to discontinue your research before its planned completion you must also advise the Chair of the Sub-Committee of the circumstances.
- In the event of any adverse effects on subjects, or unforeseen events, which may affect the ethical acceptability of your project, you should immediately report to the Chair of the Sub-Committee.
- Also we were recently advised that any research data, which identifies people and that is stored in electronic form, should be held on CD, Zip Disk or diskette. It should not be stored on a computer that is connected to the web or to a network.

Let me take this opportunity to wish you all the best with your research. If any issues regarding ethics arise during the running of the project, please do not hesitate to contact the Chair of the Sub-Committee.

Sincerely

Lina Papillo  
 Secretary, SET Portfolio Human Research Ethics Sub-Committee (Non-Biomedical)

**APPENDIX B: RMIT HREC Consent Form for the Study**  
RMIT HUMAN RESEARCH ETHICS COMMITTEE

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**Prescribed Consent Form For Persons Participating In Research Projects Involving Interviews,  
Questionnaires or Disclosure of Personal Information**

<b>SCHOOL OF</b>	<u>Health Sciences</u>
<b>DIVISION OF</b>	<u>Psychology</u>
Name of participant:	
Project Title:	<u>Brides &amp; Grandmothers: Challenges for older Filipinos In Australia</u>
Name(s) of investigators:	<u>Tonette Butler Wilks</u> Phone: <u>99252750</u>
(1)	<u>(Student Researcher)</u>
(2)	<u>Trang Thomas</u> Phone: <u>99253294</u>
	<u>(Supervisor)</u>

1. I have received a statement explaining the interview/questionnaire involved in this project.
2. I consent to participate in the above project, the particulars of which - including details of the interviews or questionnaires - have been explained to me.
3. I authorise the investigator or his or her assistant to interview me or administer a questionnaire.
4. I acknowledge that:
  - (a) Having read Plain Language Statement, I agree to the general purpose, methods and demands of the study.
  - (b) I have been informed that I am free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied.
  - (c) The project is for the purpose of research and/or teaching. It may not be of direct benefit to me.
  - (d) The privacy of the personal information I provide will be safeguarded and only disclosed where I have consented to the disclosure or as required by law.
  - (e) The security of the research data is assured during and after completion of the study. The data collected during the study may be published, and a report of the project outcomes will be provided to RMIT University & Filipino council. Any information which will identify me will not be used.

**Participant's Consent**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Participant)

## APPENDIX C: RMIT HREC Plain Language Statement CLs – Stage 1

### INVITATION TO PARTICIPATE IN A RESEARCH PROJECT

#### Stage 1 PROJECT INFORMATION STATEMENT for Community Leaders

#### Project Title: Brides & Grandmothers: Challenges for older Filipinos in Australia

Dear Participant,

My name is Antonietta (Tonette) Butler Wilks and I am a PhD student researcher conducting this project at RMIT University Division of Psychology. I am inviting you to participate in Stage 1 of a research project I am undertaking that is funded by the Australian Research Council (ARC) and being supervised by Professor Trang Thomas. This project has been approved by the RMIT Human Research Ethics Committee and has the full support of the Filipino Community Council of Victoria, Inc. (FCCVI) and many Filipino senior citizens' associations.

#### ***What is the project about?***

Few scientific studies have been undertaken about the Filipino migrant community as they grow old. It is uncertain how many older Filipinos confront maintaining employment and caring for their grandchildren or elderly parents, and how this role impacts on their health, relationships and well-being. Your participation will provide valuable information on the association between caregiving experience, general health, and use of services of older Filipinos. The study is being conducted in two stages. Over-all results from this project will be used by FCCVI to develop the community's 10-year Strategic Plan for Positive Ageing and Community Support Services for older people in urban and isolated areas.

#### ***If I agree to participate, what will I be required to do?***

Stage 1 is a semi-structured group interview designed to identify general issues that old Filipino migrants face.

If you are happy to participate in Stage 1, please sign the attached Consent Form and return it to me. I will organise a two-hour group interview with you and other people at a time and place most convenient for you.

#### ***What are my rights as a participant? What will happen to the information I provide?***

Your participation is entirely voluntary and you have the right to withdraw your participation at any time. According to Australian law, the information collected will be treated with utmost confidentiality and anonymity. This means that participants cannot be identified and the data will be stored securely.

***Who should I contact if I have any questions?*** If you have any questions, please call Prof. Trang Thomas on (03) 9925 3294 or email [trang.thomas@rmit.edu.au](mailto:trang.thomas@rmit.edu.au) or D. Sophia Xenos on (03) 9925 1081 or email [sophia.xenos@rmit.edu.au](mailto:sophia.xenos@rmit.edu.au). All discussions will be confidential.

Antonietta (Tonette) Butler Wilks  
BSc Psych, PG Psych, MPsych  
Student Researcher

Professor Trang Thomas, AM  
PhD  
Supervisor

Any complaints about your participation in this project may be directed to the Secretary, RMIT Human Research Ethics Committee, University Secretariat, RMIT, GPO Box 2476V, Melbourne, 3001. The telephone number is (03) 9925 1745. Details of the complaints procedure are available from the above address.

## APPENDIX D: RMIT HREC Plain Language Statement FWV – Stage 1

### INVITATION TO PARTICIPATE IN A RESEARCH PROJECT Stage 1 PROJECT INFORMATION STATEMENT for Participants

#### Project Title: Brides & Grandmothers: Challenges for older Filipinos in Australia

Dear Participant,

My name is Antonietta (Tonette) Butler Wilks and I am a PhD student researcher conducting this project at RMIT University Division of Psychology. I am inviting you to participate in Stage 1 of a research project I am undertaking that is funded by the Australian Research Council (ARC) and being supervised by Professor Trang Thomas. This project has been approved by the RMIT Human Research Ethics Committee and has the full support of the Filipino Community Council of Victoria, Inc. (FCCVI) and many Filipino senior citizens' associations.

#### *What is the project about?*

Few scientific studies have been undertaken about the Filipino migrant community as they grow old. It is uncertain how many older Filipinos confront maintaining employment and caring for their grandchildren or elderly parents, and how this role impacts on their health, relationships and well-being. Your participation will provide valuable information on the association between caregiving experience, general health and use of services of older Filipinos. The study is being conducted in two stages. Over-all results from this project will be used by FCCVI to develop the community's 10-year Strategic Plan for Positive Ageing and Community Support Services for older people in urban and isolated areas.

#### *If I agree to participate, what will I be required to do?*

Stage 1 is a semi-structured group interview designed to identify general issues that old Filipino migrants face during settlement and in adjusting to their role as caregiver. Participants will be asked about:

1. Demographic Information;
2. Migration circumstances;
3. Caregiving experience; and
4. Use of support services.

If you are happy to participate in Stage 1, please sign the attached Consent Form and return it to me. I will organise a two-hour group interview with you and other people at a time and place most convenient for you.

#### *What are my rights as a participant? What will happen to the information I provide?*

Your participation is entirely voluntary and you have the right to withdraw your participation at any time. According to Australian law, the information collected will be treated with utmost confidentiality and anonymity. This means that participants cannot be identified and the data will be stored securely.

**Who should I contact if I have any questions?** If you have any questions, please call Prof. Trang Thomas on (03) 9925 3294 or email [trang.thomas@rmit.edu.au](mailto:trang.thomas@rmit.edu.au) or D. Sophia Xenos on (03) 9925 1081 or email [sophia.xenos@rmit.edu.au](mailto:sophia.xenos@rmit.edu.au). All discussions will be confidential.

Antonietta (Tonette) Butler Wilks  
BSc Psych, PG Psych, MPsyCh  
Student Researcher

Professor Trang Thomas, AM  
PhD  
Supervisor

Any complaints about your participation in this project may be directed to the Secretary, RMIT Human Research Ethics Committee, University Secretariat, RMIT, GPO Box 2476V, Melbourne, 3001. The telephone number is (03) 9925 1745. Details of the complaints procedure are available from the above address.

## APPENDIX E: List of Proposed CL Focus Group Questions - Stage 1

### Stage 1 Community Leaders Focus Group Questions

\_\_\_/\_\_\_/\_\_\_

1 Organization you represent \_\_\_\_\_

2 Type of service: \_\_\_ Government \_\_\_ Non-government

3 Services provided by your organization:

General Practitioner	Private Service	Home Nursing
Specialist	Residential Service	Home Mod/Main
Other Health	Residential Respite Service	Home Help
Community Access	Aged Care Service	In Home Respite
Carer Support	Disability Service	Out of Home Respite
Carer Info and Training	Informal Support	Personal Care
Settlement	Food Service	Recreation
Brokerage	Equipment	Neighbour Aid
Transport	Hospital	Other

4 Does your service target:

\_\_\_ People aged 45 years and over

\_\_\_ Adults with disability: 1 Physical 2 Mental 3 intellectual

\_\_\_ Families/ Carers of people with disability 1 Physical 2 Mental 3 intellectual

\_\_\_ Others \_\_\_\_\_

5 Over 12 months, how many client from your services have been from

a. CALD background? \_\_\_\_\_

b. Filipino background? \_\_\_\_\_

6 What makes it easy or hard for you to provide services to CALD particularly Filipino Community \_\_\_\_\_

7 What make it easy or hard for your service/site to provide to offer excellent service most particularly Filipino community to CALD?

Thank you very much for you time and contribution.



## APPENDIX F: List of Proposed FWV Focus Group Questions (English) - Stage 1

### Stage 1 Filipino Women in Victoria Focus Group Questions

**Date of Interview:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Consent Form signed: \_\_ Yes \_\_ No

Name of Participant: \_\_\_\_\_

Age (current): \_\_\_\_\_ Gender (circle): \_\_ Female \_\_ Male

Marital Status (current): \_\_ Single/Never married \_\_ Married \_\_ De-facto \_\_ Separated  
 \_\_ Divorced \_\_ Widowed

If married/widowed, married to: \_\_ Filipino \_\_ Non-Filipino or Australian

Religion: \_\_ Roman Catholic \_\_ Protestant \_\_ Iglesia ni Cristo \_\_ Buddhist \_\_ Islam  
 \_\_ Other \_\_\_\_\_

Birthplace in the Philippines: \_\_\_\_\_ City \_\_ Town \_\_ Barrio

Suburb or town of current address: \_\_\_\_\_

Do you currently live in: \_\_ own house/flat \_\_ rent a house/flat \_\_ boarding/shared accommodation \_\_ hostel  
 assisted accommodation \_\_ nursing home \_\_ retirement unit

Do you currently live: \_\_ Alone 2 \_\_ with husband/wife \_\_ with family \_\_ with adult children and  
 grandchildren \_\_ with other relatives \_\_ with people not related to me

What language do you speak at home now? \_\_ Tagalog \_\_ English \_\_ both \_\_ Phil. Dialect

When did you migrate to Australia? \_\_\_\_\_

What was your visa then? \_\_ Bride/fiancée \_\_ Spouse \_\_ Independent \_\_ Skilled Migrant  
 \_\_ Student \_\_ Business Migrant \_\_ Family Reunion \_\_ Tourist \_\_ Other \_\_\_\_\_

What is your visa now? \_\_\_\_\_

Did you migrate \_\_ Alone \_\_ with Partner \_\_ with partner & children \_\_ with others \_\_\_\_\_

Were you single \_\_ married \_\_ de-facto \_\_ separated \_\_ divorced \_\_ widowed prior to arriving to Australia?

Have you been to Australia before migrating? \_\_ yes \_\_ no

What was your reason for migrating to Australia? \_\_\_\_\_

How keen were you to migrate? \_\_ very keen \_\_ keen \_\_ ambivalent/unsure

If you were unsure, what concerns did you have? \_\_\_\_\_

What were your expectations of Australia prior to migrating? Were they met? \_\_ Yes \_\_ N

How would you describe your first years of adjustment in Australia?

What were the good things about coming to Australia?

---

What were the difficulties? How did you manage them?

---

Do you still have the same or have they changed? –Yes \_\_\_No How do you manage now?

---

Have you been a caregiver either for your spouse or grandchild or parent or other relatives or friends in Australia? \_\_\_Yes \_\_\_No.

If yes,

Is the person your \_\_\_Spouse \_\_\_Grandchild \_\_\_Parent \_\_\_Others

Are you still caring for them? \_\_\_ Yes \_\_\_No or Somebody else and who? \_\_\_\_\_

How do you manage as a caregiver ? \_\_\_\_\_

---

Or as a person being cared for by another person ?

---

What are the circumstances that led you to becoming the carer for your Spouse/Grandchild/Parent?

---

What are the challenges and reward of your role?

---

What type of social services so you and your spouse/grandchild/parent need?

---

Which services do you access?

---

Do you find their service provision adequately meeting your needs and needs of your spouse/grandchild/parent?

---

What do you prefer health and social service agencies provide so that they can be more responsive to the needs of families in similar situations?

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## APPENDIX G: List of Proposed FWV Focus Group Questions (Pilipino) - Stage 1

### Stage 1 Focus group Questions: Pilipino

1. Kasulatan ng Pagsangayon: \_\_\_\_ Oo \_\_\_\_ Hindi
2. Pangalan ng Kasali: Bb/Gi/Gng/Dr \_\_\_\_\_
3. Gulang (ngayon): \_\_\_\_\_ Kasarian (Bilugan) \_\_\_\_ Babae \_\_\_\_ Lalaki
4. Katayuan ngayon: \_\_\_\_ Nag-iisa/Hindi nag-asawa \_\_\_\_ May-asawa \_\_\_\_  
\_\_\_\_ De-facto \_\_\_\_ Hiwalay \_\_\_\_ Diborsiyada/do \_\_\_\_ Balo
5. Kung may-asawa/balo, nag-sawa ng: \_\_\_\_ Pilipino \_\_\_\_ Hindi Pilipino or Australyano
6. Relihiyon: \_\_\_\_ Katoliko Romano \_\_\_\_ Protestante \_\_\_\_ Inglesia ni Kristo  
\_\_\_\_ Budista \_\_\_\_ Islam \_\_\_\_ Iba pa \_\_\_\_\_
7. Lugar ng kapanganakan sa Pilipinas: \_\_\_\_\_. \_\_\_\_ Siyudad \_\_\_\_ Bayan \_\_\_\_ Barrio
8. Lugar o bayan ng tirahan ngayon: \_\_\_\_\_
9. Nakatira ba kayo: \_\_\_\_ sariling bahay/flat \_\_\_\_ umuupa ng bahay/flat  
\_\_\_\_ kahati sa tinutuluyan \_\_\_\_ hostel \_\_\_\_ nursing home \_\_\_\_ retirement unit
10. Ikaw ba ay naninirhan ngayon: \_\_\_\_ Nag-iisa \_\_\_\_ kasama and asawa \_\_\_\_ may pamilya  
\_\_\_\_ kasama ng anak at apo \_\_\_\_ kasama ng ibang kamag-anak  
\_\_\_\_ kasama ng ibang tao na hindi kamag-anak
11. Ano ang wikang sinasalita mos sa bahay ngayon? \_\_\_\_ Tagalog \_\_\_\_ English  
\_\_\_\_ pareho \_\_\_\_ Philippine dialect
12. Kailan ka nggibang bansa sa Australya? \_\_\_\_\_
13. Ano ang bisa mo noon? \_\_\_\_ Mapapangasawa \_\_\_\_ Kabiya \_\_\_\_ Independente  
\_\_\_\_ Skilled na Migrante \_\_\_\_ Mag-aaral \_\_\_\_ Negosyate Migrante  
\_\_\_\_ Family Reunion \_\_\_\_ Turista \_\_\_\_ Iba pa \_\_\_\_\_
14. Ano ang bisa mo ngayon? \_\_\_\_\_
15. Ikaw ba ay nagibang bansa \_\_\_\_ magisa \_\_\_\_ kasama ag asawa  
\_\_\_\_ kasama ang asawa at anak \_\_\_\_ kasama ng iba \_\_\_\_\_
16. Ikaw ba ay \_\_\_\_ dalaga/binata? \_\_\_\_ mayasawa \_\_\_\_ de-facto \_\_\_\_ hiwalay \_\_\_\_ doborsida/do  
\_\_\_\_ balo bago maginbang bansa sa Australya?
17. Nakarating ka na ba sa Australya bago ka nagibang bansa bilang migrante?  
\_\_\_\_ Oo \_\_\_\_ Hindi
18. Ano ang dahilan ng pangingibang bansa mo sa Australya?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
19. Gaano kasidhi ang pangingibang bansa mo? \_\_\_\_ Matindi \_\_\_\_ Hindi gaano  
\_\_\_\_ Nagaalanganin/Hindi tiyak
20. Kung hindi tiyak, ano ang inaalala mo?  
\_\_\_\_\_  
\_\_\_\_\_
21. Ano ang inaasahan mo sa Australya bago ka mangibang bansa? Nakamit mo ba it? \_\_\_\_ Oo \_\_\_\_ Hindi
22. Paano mo ihahawig and mga unang taon mo sa pag-akma sa buhay Australya?  
\_\_\_\_\_  
\_\_\_\_\_

23. Ano ang mga maganda tungkol sa pagpunta sa Australya?

---

24. Ano ang mga kahirapan/balakid? Paano mo pinamahalaan ito?

---

25. Mayroon ka pa rin bang balakid or kahirapan o nagbago na ba ito? \_\_ Oo \_\_ Hindi

26. Paano mo pinamamahalaan ito? \_\_\_\_\_

27. Ikaw ba ay nagin tapag-alaga or tagapagbigay ng kalinga sa iyong asaw or apo o magulang o ibang kamag-anak o kaiibigan sa Australya? \_\_Oo \_\_ Hundi

28. Kung Oo, siya ba ay iyong \_\_ Asawa \_\_ Apo \_\_ Magulang \_\_ Ibang tao

29. Ikaw ba ay nag-aalaga pa rin sa kanila? \_\_Oo \_\_ Hindi o

Kung bang tao na ngayon, sino? \_\_\_\_\_

30. Paano mo pinamamahalaan bilang tagapag-alaga? \_\_\_\_\_

---

31. O bilang isang tao na inaaalagan ng ibang tao? \_\_\_\_\_

32. Ano ang mga pagyayari na nagging tagapagalaga kayo ng iyong asaw/apo/magulang?

---

33. Ano ang mga hamon at gantimpala sa iyo bilang tagapagalaga?

---



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34. Ano ang mga serbisyong pantulong na kailangan mo ant ang iyong asawa/apo/magulang?

35. Ano ang mga serbisyo na ginagamit mo? \_\_\_\_\_

---

36. Ang mga serbisyong ito ay tumutugon ba sa pangangailangan mo at ng iyong sawa/apo/magulan? \_\_ Oo \_\_ Hindi. Bakit? \_\_\_\_\_

37. Ano pa ng ibang pngkalusugan at pantulong na serbisyo na gusto mo na maialok sa mga pamilya na katulad mo ang kalagayan? \_\_\_\_\_

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## APPENDIX H: RMIT HREC Plain Language Statement - Stage 2

### INVITATION TO PARTICIPATE IN A RESEARCH PROJECT

#### STAGE 2 PROJECT INFORMATION STATEMENT

##### Project Title:

**Brides & Grandmothers: Challenges for older Filipinos in Australia**

##### Investigators:

Tonette Esmaquel Butler Wilks  
PhD Student Researcher, RMIT University

Professor Trang Thomas, AM  
Project Senior Supervisor, RMIT University  
[trang.thomas@rmit.edu.au](mailto:trang.thomas@rmit.edu.au), 9925 3294

Dr. Sophia Xenos  
Project Second Supervisor, RMIT University  
[sophia.xenos@rmit.edu.au](mailto:sophia.xenos@rmit.edu.au), 9925 1081

You are invited to participate in a research project being conducted by RMIT University with the support of various Filipino organisations.

**Who is involved in this research project? Why is it being conducted?** Tonette Butler Wilks is a PhD research student conducting this project at RMIT University Division of Psychology with scholarship grant from Asian Australian Research Council. The project has been approved by the RMIT Human Research Ethics Committee.

Few scientific studies have been undertaken to explore the migration circumstances and settlement experiences of the Filipino migrant community in urban and rural areas and the impact of their caregiving experiences on their general well-being and social support needs as they grow old. Results from this project will provide the Filipino community with valuable data that will be used by the Industry Partner to develop the community's 10-year Strategic Plan for Positive Ageing and Community Aged Services. The study will also provide information about preventative healthcare to health professionals and planners so that positive mental health in the ageing Filipino community can be promoted.

**If I agree to participate, what will I be required to do?** Participation in this study is entirely voluntary. If you agree to participate please sign the attached Consent Form and complete a Questionnaire Package that has been translated from English to Pilipino. You can choose which version to complete.

The package includes: the **Filipino Experience Questionnaire** to obtain information on age, gender, year of arrival and type of visa, migration, adjustment and caregiving experience; **Acculturation Scale** to assess level of cultural identification in terms of language and friends; **Health Questionnaires** to obtain information on health and well-being; **Coping Questionnaires** to assess individual coping styles; and **Caregiving Questionnaire** to assess how a person feels when taking care of another person. Each questionnaire is short, multiple choice or yes or no format and takes about 5-10 minutes to complete. Completing the package may take approximately 30-45 minutes so participants can take small breaks.

**What will happen to the information I provide and my rights as a participant?** According to Australian regulations, the information collected will be treated with utmost confidentiality and anonymity. After completion of the study, Tonette will be happy to discuss over-all findings with you. You have the right to withdraw your participation at any time.

**Who should I contact if I have any questions?** If you have any questions about the project, please ask one of the investigators. You may also contact Tonette on 0409 958 594 or leave a message with **Administrator Ms. Jan Elliot** on (03) 9925 2750. All discussions will be confidential. Alternatively, please address your letters to:

**Antonietta Butler Wilks, Division of Psychology, School of Health Sciences,  
RMIT University, PO BOX 71, Bundoora 3081**

Thank you for your interest and support.

Tonette Butler Wilks  
MPsych  
Student Researcher

Prof Trang Thomas, AM  
PhD  
Senior Supervisor

Dr Sophia Xenos  
PhD  
Second Supervisor

Any complaints about your participation in this project may be directed to the Secretary, RMIT Human Research Ethics Committee, University Secretariat, RMIT, GPO Box 2476V, Melbourne, 3001. The telephone number is (03) 9925 1745. Details of the complaints procedure are available from the above address.

**APPENDIX I: Questionnaire Package (English) – Stage 2**
**QUESTIONNAIRE BOOKLET**

This booklet contains a series of questionnaires designed to measure migration experience, caregiving experience general health and psychological health, relationship with others, ways of managing stress and services used. There are no right or wrong answers so try very hard to be honest in your answers.

**PART 1. PERSONAL INFORMATION**

*(Please circle one answer where indicated, unless given option to circle more than one.)*

**1. AGE (current):** \_\_\_\_\_ **2. Date of birth:** \_\_\_\_\_

**3. GENDER (circle):** 1 Female 2 Male

**4. MARITAL STATUS (current):**

1 Single/Never married	3 Separated/ Divorced
2 Married/ De-facto	4 Widowed

**5. If currently married/de-facto is your partner a:** 1 Filipino 2 Non Filipino or Australian

**6. If previously married/widowed, your partner was a:** 1 Filipino 2 Non-Filipino or Australian

**7. Your RELIGION:**

1 Catholic	2 Other Christian denominations	3 Islam/Muslim	4 Other
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**8. Your Highest EDUCATION achieved:**

1 Primary	2 Secondary	3 College/Univ	4 Other(Vocational)	5 Postgrad
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**9. Your Wife/husband/partner's highest educational attainment:**

1 Primary	2 Secondary	3 College/Univ	4 Other(Vocational)	5 Postgrad
-----------	-------------	----------------	---------------------	------------

**10. Your Wife/husband/partner's age or year of birth:** \_\_\_\_\_

**11. How many CHILDREN do you have in Australia?** \_\_\_\_\_

**12. How many CHILDREN are in Philippines/other countries?** \_\_\_\_\_

**13. Your BIRTHPLACE in the Philippines:** \_\_\_\_\_

**14. Type of birthplace:** 1 City/Metropolitan 2 Rural/remote/barrio

**15. Suburb/town of your CURRENT ADDRESS:** \_\_\_\_\_

**16. Type of current address in Australia:** 1 City/Metropolitan 2 Rural/remote/barrio

**17. Are you currently residing in:**

1 Own/paying house/flat/unit	4 Rent private house/flat/unit
2 Children's house	5 Nursing home/hostel
3 Other relatives' home	6 Retirement unit
7 Other	

**18. Do you currently live:**

1 Alone	3 With partner & children	5 With other relative
2 With spouse/partner	4 With adult child & grandchildren	6 With Other people not related to me

**19. What is your EMPLOYMENT Status now?**

1 Retired	2 Full Time work	3 Part Time work	4 Not working
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**20. If currently working, what TYPE OF WORK do you do now?**

1 Managerial/ Supervisor	2 Professional eg. GP, Nurse, CPA, Lecturer, etc	3 Trade/Industry eg. Mechanic	4 Administrative/ Office/Computer/ Sales	5 Other
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**21. What is your current main source of INCOME?**

1 Salary/Wage	2 Pension	3 Own Business/ Investments	4 Other
---------------	-----------	--------------------------------	---------

**PART 2. MIGRATION EXPERIENCE****22. What YEAR did you migrate to Australia? \_\_\_\_\_****23. What was your VISA when you migrated?**

1 Bride/fiancée/ Spouse	2 Independent/Skilled	3 Family Reunion	4 Other
-------------------------	-----------------------	------------------	---------

**PART 2.1 Before Migrating to Australia****24. Were you employed before you migrated to Australia? 1 Yes 2 No****25. If, Yes, what type of WORK was it?**

1 Managerial/ Supervisor	2 Professional eg. GP, Nurse, CPA	3 Trade/Industry eg. Mechanic,	4 Administrative/ Office/Sales	5 Other
-----------------------------	--------------------------------------	-----------------------------------	-----------------------------------	---------

**26. Had you been to Australia before migrating? 1 Yes 2 No****27. How INTERESTED were you to migrate? 1 Very interested 2 Interested 3 Not sure****28. What was your main REASON/EXPECTATION for migrating to Australia?**

1 Marriage/join spouse/fiancée	2 Care for grandchildren	3 Other
--------------------------------	--------------------------	---------

**29. Did your expectation about migration become a reality? 1 Yes 2 No****30. What CONCERNS did you have about migrating to Australia? (Circle three only).**

1 Being away from the rest of family & friends	5 If marriage would work
2 Adjusting to different race, culture & language	6 If employment would be successful
3 Weather – might be too cold	7 Loss/change of status in family &/or society
4 None	8 Other

**PART 2.2 Soon After Migrating to Australia****31. How would you describe your FIRST YEARS OF ADJUSTMENT in Australia?**

1 Easy/Almost No problem	2 Hard/Difficult	3 Very hard/Very difficult
--------------------------	------------------	----------------------------

**32. What helped you settle in Australia? (Circle three only).**

1 Church/spiritual services	5 Family	9 Schools/Universities
2 Migration services/lawyer	6 Friends	10 Medical & allied health
3 Child & family services	7 Centrelink/ Police	11 Women's Refuge/Outreach
4 Professional associations	8 Filipino Social/Sports clubs	12 Other

**PART 2.3 Marin Acculturation Scale**

Please read each statement and circle a number 0, 1, 2, 3, 4 or 5 which indicates how much the statement apply to you. There are no right and wrong answers.	Only Pilipino/ Dialect	More Pilipino/ Dialect than English	Both equally	More English than Pilipino	Only English
--	------------------------------	---	-----------------	-------------------------------------	-----------------

1. In general, what language(s) do you read and speak?	1	2	3	4	5
2. What was the language(s) you used to use as a child?	1	2	3	4	5
3. What language(s) do you usually speak at home?	1	2	3	4	5
4. In which language(s) do you really think?	1	2	3	4	5
5. What language(s) do you usually speak with your friends?	1	2	3	4	5
6. In what language(s) are the T.V. programs you usually watch?	1	2	3	4	5
7. In what language(s) are the radio programs you usually listen to?	1	2	3	4	5
8. In general, what language(s) are the movies, T.V. and radio programs you prefer to watch and listen to?	1	2	3	4	5
9. Your close friends are	1	2	3	4	5
10. You prefer going to social gatherings/parties at which people are	1	2	3	4	5
11. The persons you wish to visit you are	1	2	3	4	5
12. If you could choose your children's friends you would want them to be	1	2	3	4	5

### PART 3. AGEING IN AUSTRALIA

#### 33. What do you consider makes a person old?

1 Age of the person From what age? _____ yrs old	2 Already a grandparent regardless of age	3 An adult who is frail &/or has a disability and needs care	4 Other reason (specify)
--	--	--	--------------------------

#### 34. What services do you prefer to be available as you get older in Australia? (Circle three only).

1 Aged care services at home	6 Outdoor activities eg, field trips
2 Care in Multicultural Hostels/Nursing Homes	7 Cultural activities eg, fiestas, singing
3 Filipino residential facility run by Filipinos	8 Filipino meals on wheels
4 Drop-in centres	9 Planned activities in door eg, woodwork, crafts
5 Health information sessions	10 Social support eg, Friendly visiting program, Neighbourhood support by Filipinos, Day Centre
11 Other (Pls. specify):	

#### 35. Who do you want to live with in your old age in Australia?

1 Spouse	2 Children	3 Friends	3 Other relatives	4 Workers
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#### 36. Where would you prefer to receive care if you get very weak/sick in old age?

1 At home	2 Serviced hostel/Nursing home	3 Philippines
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#### 37. What services would you prefer?

Services .....	Least likely	May consider	Most likely
1 By professional Filipino workers only	1	2	3
2 By professional Non-Filipino workers only	1	2	3
3 Mixed, that is, by professional Filipinos & non-Filipinos	1	2	3

### Part 4. DASS 21 Scale

Please read each statement and circle a number 0, 1, 2, or 3 which indicates how much the statement applied to you OVER THE PAST WEEK. There are no right and wrong answers. Do not spend too much time on any statement. The rating scale is as follows:

It applied to me .....	Not at all	Some of the time	Good part of the time	Most of the time
1. I found it hard to wind down	0	1	2	3
2. I was aware of dryness of my mouth	0	1	2	3
3. I couldn't seem to experience any positive feeling at all	0	1	2	3
4. I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5. I found it difficult to work up the initiative to do things	0	1	2	3
6. I tended to over-react to situations	0	1	2	3
7. I experienced trembling (eg, in the hands)	0	1	2	3
8. I felt that I was using a lot of nervous energy	0	1	2	3



9. I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10. I felt that I had nothing to look forward to	0	1	2	3
11. I found myself getting agitated	0	1	2	3
12. I found it difficult to relax	0	1	2	3
13. I felt down-hearted and blue	0	1	2	3
14. I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15. I felt I was close to panic	0	1	2	3
16. I was unable to become enthusiastic about anything	0	1	2	3
17. I felt I wasn't worth much as a person	0	1	2	3
18. I felt that I was rather touchy	0	1	2	3
19. I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20. I felt scared without any good reason	0	1	2	3
21. If I died tomorrow, very few people would miss me	0	1	2	3

#### Part 4. Brief COPE Scale

These items deal with ways you've been coping with stress in your life since you migrated to Australia. Each item says something about a particular way of coping. I want to know to what extent you do what the item says. How much or how frequently. Don't answer on the basis of whether it seems to be working or not – just whether or not you're doing it. Use these response choices. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can.

I usually do this .....	Not at all	Little bit	Medium amount	A lot
1. I turn to work or other activities to take my mind off things.	1	2	3	4
2. I concentrate my efforts on doing something about the situation I'm in.	1	2	3	4
3. I say to myself "this isn't real."	1	2	3	4
4. I use alcohol or drugs to make myself feel better.	1	2	3	4
5. I get emotional support from others.	1	2	3	4
6. I give up trying to deal with it.	1	2	3	4
7. I take action to try to make the situation better.	1	2	3	4
8. I refuse to believe that it happened.	1	2	3	4
9. I say things to let my unpleasant feelings escape.	1	2	3	4
10. I get help and advice from other people.	1	2	3	4
11. I use alcohol or other drugs to help me get through it.	1	2	3	4
12. I try to see it in a different light, to make it seem more positive.	1	2	3	4
13. I criticize myself.	1	2	3	4
14. I try to come up with a strategy about what to do.	1	2	3	4
15. I get comfort and understanding from someone.	1	2	3	4
16. I give up attempt to cope.	1	2	3	4
17. I look for something good in what is happening.	1	2	3	4
18. I make jokes about it.	1	2	3	4
19. I do something to think about it less, such as going to movies, watching TV, reading,	1	2	3	4

daydreaming, sleeping, or shopping.				
20. I accept the reality of the fact that it has happened.	1	2	3	4
21. I express my negative feelings.	1	2	3	4
22. I try to find comfort in my religion or spiritual beliefs.	1	2	3	4
23. I try to get advice or help from other people about what to do.	1	2	3	4
24. I learn to live with it.	1	2	3	4
25. I think hard about what steps to take.	1	2	3	4
26. I blame myself for things that happened.	1	2	3	4
27. I pray or meditate.	1	2	3	4
28. I make fun of the situation.	1	2	3	4

#### Part 4. Social Support Appraisal Scale

Please read each statement and circle a number 0, 1, 2, 3 or 4 which indicates how much you agree with the statement. There are no right and wrong answers. The rating scale is as follows:

	Strongly Agree	Agree	Disagree	Strongly Disagree
1. My friends respect me	1	2	3	4
2. My family cares for me much	1	2	3	4
3. I am not important to others	1	2	3	4
4. My family holds me in high esteem	1	2	3	4
5. I am well liked	1	2	3	4
6. I can rely on my friends	1	2	3	4
7. I am really admired by my family	1	2	3	4
8. I am respected by other people	1	2	3	4
9. I am loved dearly by my family	1	2	3	4
10. My friends don't care about my welfare	1	2	3	4
11. Members of my family rely on me	1	2	3	4
12. I am held in high esteem	1	2	3	4
13. I can't rely on my family for support	1	2	3	4
14. People admire me	1	2	3	4
15. I feel strong bond with my friends	1	2	3	4
16. My friends look out for me	1	2	3	4
17. I feel valued by others	1	2	3	4
18. My friends really respect me	1	2	3	4
19. My friends and I are really important to each other	1	2	3	4
20. I feel like I belong	1	2	3	4
21. If I died tomorrow, very few people would miss me	1	2	3	4
22. I don't feel close to my family members	1	2	3	4
23. My friends and I have a lot for one another	1	2	3	4

38. Is there anything else you would like to say? \_\_\_\_\_

39. Have you been or are you currently a CARER (*Taga-alaga*) either for your spouse or grandchild or parent or other relatives or friends in Australia?

1 Yes, please answer PART 5.

2 No, STOP here.

*Thank you for your time and support.***PART 5. CAREGIVING (PAG-AALAGA) EXPERIENCE****40. Is the Caree (*Inaalagaan*) your:**

1 Spouse	2 Grandchild	3 Both spouse & Grandchild	4 Parent	5 Other
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**41. Did/Do you live with the Caree?**

1 Yes

2 No

**42. If No, where did/does your Caree live?**

1 At home with parents	2 Nursing home	3 Hostel like Lions	4 Others
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**43. Are you still caring for them?**

1 Yes

2 No

**44. How long did/have you been the Carer(*Taga-alaga*)? \_\_\_\_\_****45. Are you caring for a different person now?**

1 Yes

2 No,

**46. If Yes, what is your relationship to them?**

1 Spouse	2 Grandchild	3 Parent	4 Adult child	5 Friend	6 Other relative
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**47. Why did you become the Carer (*Taga-alaga*) for your Spouse/Grandchild/Parent?**

1 So parents could do paid work	3 Give parents a break
2 Illness of spouse/parent/others	4 <i>Utang na loob</i> (eg, They paid for my fare/visa.)

**48-49. For grandparents caring for grandchildren, how many grandchildren did/do you cared for? \_\_\_\_\_ and****How old were they? \_\_\_\_\_****50. What were/are the (REWARDS) positive aspects of your role as Carer(*Taga-alaga*)?***(Circle three only).*

1 Follow Filipino custom to care for own family	6 Happy & satisfied to help/care for family
2 Teach Filipino values, language & culture	7 Closer relationship with family
3 Set example to our children, so when we grow old, they would also do care for us	8 Understanding of health system & human services available
4 Adult children give some money	9 Good relationship with Australian in-law
5 Feel confident relatives caring for our children	10 Feel useful, meaningful life

**51. Did/do you access social support services?**

1 Yes

2 No

**52. If Yes, which SERVICES did/do YOU access as Carer (*Taga-alaga*)? Who provides them? (Circle as many).**

	Filipino	Australian
1 Centrelink		
2 Carer respite	1	2
3 Day care/drop-in centre	1	2
4 Childcare/playgroup	1	2
5 Transport support	1	2
6 Doctors and allied health	1	2
7 Telelink program, Friendly visiting program	1	2
8 Church activities/spiritual director	1	2
9 Advocacy/Outreach	1	2

**53. How satisfied were/are you with these services? (Circle as many).**

	Not satisfied	Satisfied	Very satisfied
1 Centrelink	1	2	3
2 Carer respite	1	2	3
3 Day care/drop-in centre	1	2	3
4 Childcare/playgroup	1	2	3
5 Transport support	1	2	3
6 Doctors and allied health	1	2	3
7 Telelink program, Friendly visiting program	1	2	3
8 Church activities/spiritual director	1	2	3
9 Advocacy/Outreach	1	2	3

**54. If you are not accessing services, why not?**

1 Not knowing about them	3 Quality not good
2 Not culturally appropriate	4 Other

**55. What type of SERVICES did/does your CAREE need? (Circle as many).**

1 Child care	3 Residential care (eg, Nursing home)
2 Aged care services at home	4 Cluster Home (eg, Lions Seniors Homes)

**56. How satisfied were/are you with these services?**

	Not satisfied	Satisfied	Very satisfied
1 Child care	1	2	3
2 Aged care services at home	1	2	3
3 Residential care (eg, Nursing home)	1	2	3
4 Cluster Home (eg, Lions Seniors Homes)	1	2	3

**57. How important are these services to you?**

	Not Important	Important	Very Important
1 Taxi concession for carers when not with Caree	1	2	3
2 Intensive outreach by Filipino professionals	1	2	3
3 Babies group for grandparents	1	2	3
4 Carer support group	1	2	3
5 In home respite	1	2	3
6 Out of home respite (Hostel, Nursing home, other aged care facilities)	1	2	3
7 Planned respite	1	2	3
8 Emergency respite	1	2	3
9 Other (pls specify):	1	2	3

**58. Are you caring for a person with Dementia or complex care needs?**      1 Yes      2 No

**59. Is there anything else you would like to say?**

\_\_\_\_\_

**60. If I would like to interview you about your life, would you agree?**      1 Yes      2 No

**61. If Yes, please leave your name and phone number:**

Name: \_\_\_\_\_ Ph No.: \_\_\_\_\_

**END of Questionnaire.**      *Thank you for your participation and support.*

## MGA TANONG sa SALITANG PILIPINO

### APPENDIX J: Questionnaire Package (Pilipino) – Stage 2

Ang mga tanong dito ay nagsusukat ng karanasan sa pangingibang bansa, pag-aalaga, pakikisama, pagaakma ng problema and paggamit ng mga serbisyo. Walang tama o mali na sagot kaya subukan ninyong maging matapat sa pagsagot.

#### BAHAGI 1. TUNGKOL SA SARILI

(Bilugan ang numero ng inyong sagot.)

1. GULANG/EDAD (ngayon): \_\_\_\_\_ 2. Taon ng Kapanganakan: \_\_\_\_\_

3. KASARIAN: 1 Babae 2 Lalaki

4. KATAYUAN (ngayon):

1 Nag-iisa/Hindi nag-asawa	3 Hiwalay
2 May asawa o kabiya	4 Biyudo/Biyuda

5. Kung ikaw ay may asawa/kinakasama ngayon, siya ay: 1 Pilipino 2 Hindi Pilipino o Australian

6. Kung dating may asawa/balo na, ang dating asawa ay: 1 Pilipino 2 Hindi Pilipino o Australian

7. RELIHIYON mo:

1 Katoliko	2 Ibang Kristiyano	3 Islam/Muslim	4 Iba pa
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8. Pinakamataas na PINAG-ARALAN:

1 Elementarya Mababang	2 Mataas na paaralan	3 Kolehiyo	4 Iba pa (Vocational)	5 Postgrad
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9. Pinakamataas na pinag-aralan ng asawa/kabiya mo:

1 Elementarya Mababang	2 Mataas na paaralan	3 Kolehiyo	4 Iba pa (Vocational)	5 Postgrad
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10. Edad or taon ng kapanganakan ng kabiya mo: \_\_\_\_\_

11. Ilan sa mga ANAK mo ang nasa Australia? \_\_\_\_\_

12. Ilan sa mga anak mo ang nasa Pilipinas/ibang bansa? \_\_\_\_\_

13. SAAN KA IPINANGANAK sa Pilipinas: \_\_\_\_\_

14. Klase ng lugar kung saan ka ipinanganak: 1 City/Metropolitan 2 Rural/probinsiya/bukid

15. Lugar ng TIRAHAN ngayon: \_\_\_\_\_

16. Klase ng lugar kung saan ka nakatira ngayon: 1 City/Suburb 2 Rural/probinsiya/bukid

17. Ikaw ba ay nakatira sa:

1 Sariling bahay/unit/flat	4 Umuupa ng bahay/unit/falt
2 Bahay ng anak	5 Nursing home/hostel
3 Bahay ng ibang kamag-anak	6 Retirement unit
7 Ibang lugar	

18. Sa ngayon, ikaw ba ay nakatirang:

1 Mag-isa	3 Kasama ng asawa/anak	5 Kasama ng ibang kamag-anak
2 Kasama ng asawa	4 Kasama ng anak at apo	6 Kasama ng hindi kamag-anak

**19. Ano ang katayuan ng inyong PAGTATRABAHO?**

1 Retirado na	2 Full Time work	3 Part Time work	4 Hindi nagtatrabaho
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**20. Kung ikaw ay nagtatrabaho, ano ang URI NG INYONG TRABAHO?**

1 Managerial/ Supervisor	2 Professional eg. GP, Nurse, CPA, Lecturer, etc	3 Trade/Industry eg. Mechanic	4 Administrative/ Office/Computer/ Sales	5 Iba pang klase
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**21. Ano ang kasalukuyan mong KITA?**

1 Suweldo	2 Pension	3 Sariling business/investments	4 Iba pang klase
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**BAHAGI 2. MIGRANTENG KARANASAN****22. Anong TAON ka nagsimulang tumira sa Australya?** \_\_\_\_\_**23. Ano ang BISA (Visa) mo noon?**

1 Bride/fiancée/ Spouse	2 Independent/Skilled	3 Family Reunion	4 Iba pang klase
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**BAHAGI 2.1 Bago ka maging migrante sa Australya****24. Ikaw ba ay nagtatrabaho/empleyado bago ka pumunta sa Australya?** 1 Oo 2 Hindi**25. Kung Oo, anong klaseng TRABAHO mo noon?**

1 Managerial/ Supervisor/Business	2 Professional eg. GP, Nurse, CPA	3 Trade/Industry eg. Mechanic	4 Administrative/ Office/Sales	5 Iba pang klase
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**26. Galing ka na ba sa Australya bago ka naging permanenteng migrante?** 1 Oo 2 Hindi**27. Gaano ka KAINTERASADONG MAGMIGRANTE?**

1 Interasadong-interesado 2 Interesado 3 Hindi sigurado

**28. Ano ang DAHILAN mong magmigrante sa Australya?**

1 Marriage/join spouse/fiancée	2 Mag-alaga ng apo	3 Iba pang klase
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**29. Natupad ba ang iyong hinahangad sa pag migrante noon?** 1 Oo 2 Hindi**30. Ano ang IPINAG-AALALA mo noon sa pagmigrante mo sa Australya?***(Tatlo lamang ang bilugan).*

1 Malayo sa mga pamilya at kaibigan	5 Kung maayos ang aking pag-aasawa
2 Makihalubilo sa ibang lahi, kultura & salita	6 Kung maging tagumpay ang pagtatrabaho
3 Panahon – masyadong malamig o mainit	7 Mawawala ang katayuan ko sa pamilya o sa iba
4 Wala akong inalala	8 Iba pang dahilan

**BAHAGI 2.2 Pagka-dating mo sa Australya****31. Paano ang iyong mga UNANG TAON NANG PAGTIRA SA AUSTRALYA?**

1 Madali/walang problema	2 Mahirap	3 Napakahirap
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**32. Ano ang nakatulong sa iyong pakikibagay (adjust) sa Australya?** *(Tatlo lamang ang bilugan).*

1 Relihiyon/simbahan	5 Pamilya	9 Paaralan/Kolehiyo
2 Migration abogado/servisyo	6 Kaibigan	10 Maggagamot at iba pa
3 Child & family services	7 Centrelink/ Police	11 Women's Refuge/Outreach
4 Professional associations	8 Pilipino Social/Sports clubs	12 Iba pang klaseng tulong

**BAHAGI 2.3 Kasalukuyang buhay sa Australia**

Basahin ang bawat tanong at bilugan kung ang 0, 1, 2, 3, 4 o 5 kung alin ang pinakatumutukoy sa inyo ngayon.	Pilipino o Dialect Lamang	Mas Pilipino o Dialect kaysa	Pareho, pantay sila	Mas Ingles/ Australyan o kaysa Pilipino	Ingles/ Austral yano Lamang
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		Ingles/Aust ralyano			
1. Sa karaniwan, anong wika ka magbasa o magsalita?	1	2	3	4	5
2. Ano ang wika mo noong ikaw ay bata pa?	1	2	3	4	5
3. Ano ang karaniwang wika mo sa bahay?	1	2	3	4	5
4. Aling wika kayo nag-iisip?	1	2	3	4	5
5. Anong wika ang karaniwan mong gamit sa pakikipag-usap sa mga kaiibigan mo	1	2	3	4	5
6. Anong wika ang mga palabas sa telebisyon na karaniwan mong pinapanood	1	2	3	4	5
7. Anong wika ng mga palatuntunan sa radio na karaniwan mong pinakikinggan?	1	2	3	4	5
8. Sa kalahatan, anong wika ng pelikula, telebisyon o radio na higit mong gustong panoorin or pakinggan?	1	2	3	4	5
9. Ang iyong malapit na mga kaiibigan ay					
10. Mas gusto mong pumunta sa panlipunang pagtitipon na ang mga tao ay	1	2	3	4	5
11. Ang mga taong gusto mong dalawin or dumalaw	1	2	3	4	5
12. Kung ikaw ay makakapili ng mga kaibigan ng anak mo, gusto mo ay	1	2	3	4	5

### BAHAGI 3. PAGTANDA SA AUSTRALYA

#### 33. Sa iyong palagay, ang isang tao ay matanda na dahil sa ....?

1 Kanilang gulang Anong gulang ito? _____ yrs old	2 May apo na kahit na anong gulang pa lamang	3 Mahina o masakitin na	4 Iba pang dahilan
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#### 34. Ano-ano ang mga serbisyo ang sana ay mayroon sa inyong pagtanda sa Australya?

(Tatlo lamang ang bilugan)

1 Aged care serbisyo sa bahay	6 Outdoor activities eg, field trips
2 Care in Multicultural Hostels/Nursing Homes	7 Cultural activities eg, fiestas, singing
3 Filipino residential facility run by Filipinos	8 Filipino meals on wheels
4 Drop-in centres	9 Planned activities in door eg, woodwork, crafts
5 Health information sessions	10 Social support eg, Friendly visiting program, Neighbourhood support by Filipinos, Day Centre
11 Iba pang klase (Isulat ito):	

#### 35. Sino ang gusto mong kasama sa inyong pagtanda sa Australya?

1 Asawa/kabiyak	2 Anak	3 Kaibigan	3 Kamag-anak	4 Manggagawa
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#### 36. Saan mo gusting tumanggap ng serbisyo pagtanda mo?

1 Sa bahay	2 Serviced hostel/Nursing home	3 Sa Pilipinas
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#### 37. Alin ang mga serbisyong mas gusto mo?

Serbisyo mula sa .....	Pinaka hindi gusto	Maaari rin	Pinaka gusto
1 Mga propesyonal na Pilipino lamang na manggagawa	1	2	3
2 Mga hindi Pilipino lamang na manggagawa	1	2	3
3 Halo, mga propesyonal na Pilipino at hindi-Pilipino	1	2	3

### BAHAGI 4. Kalusugan

Pakibasahin ang mga sumusunod at bilugan ang bilang na nagpapatunay kung ano ang inyong pakiramdam sa mga nakaraang lingo. Walang tama o maling sagot kaya huwag magtagal sa pagsagot sa bawat tanong:

Ito ay nangyayari sa akin .....	Hindi	Minsan lamang	Madalas	Sa lahat ng oras
1. Nahihirapan akong payapain ang aking kalooban	0	1	2	3
2. Alam kong natutuyo ang aking kalamunan	0	1	2	3
3. Hindi ako nakakaranas ng magandang pakiramdam	0	1	2	3

4. Nakakaranas ako ng hirap sa paghinga (mabilis na paghingasing, kinakapos sa paghinga dahil sa ehersisyo)	0	1	2	3
5. Nahihirapan akong magkusang gumawa ng mag gawain	0	1	2	3
6. Masyado akong nababahala sa nga pangayayari	0	1	2	3
7. Nakakaranas ako ng panginingig (ng kamay)	0	1	2	3
8. Pakiramdam ko ay masyado akong ninenerbiyos	0	1	2	3
9. Nangangamba ako sa situwasyon na maaaring ako ay matakot at mapahiya	0	1	2	3
10. Sa palagay ko ay wala akong hinaharap/kinabukasan	0	1	2	3
11. Napapansin ko na ako ay madaling magalit	0	1	2	3
12. Nahihirapan akong magrelaks	0	1	2	3
13. Ako ay matamlay at nalungkot	0	1	2	3
14. Madali akong mayamot kung may sagabal sa aking ginagawa	0	1	2	3
15. Pakiramdam ko madali akong matakot	0	1	2	3
16. Nahihirapan akong maging masaya kahit na sa anong bagay	0	1	2	3
17. Pakiramdam ko ay wala akong kuwentang tao	0	1	2	3
18. Ako ay maysadong maramdamin	0	1	2	3
19. Alam ko ang tibok ng puso ko kapag wala akong ehersisyo (mabilis ang tibok ng puso, kulang ang tibok ng puso)	0	1	2	3
20. Ako ay nakakaramdam ng takot ng walang dahilan	0	1	2	3
21. Pakiramdam ko ay wala ng kabuluhan ang buhay ko	0	1	2	3

#### BAHAGI 4. Pagharap sa problema sa buhay

Ito ay tungkol sa iyong paraan ng pag-akma sa problema sa iyong buhay sa Australya. Maraming mga paraan kung paano susubukang harapin ang problema. Sagutin mo ang mga bawat tanong kung ginagawa mo o hindi kahit na hindi nakakatulong. Walang tama o maling sagot, kaya piliin ang pinakaangkop na sagot para sa iyo. Bilugan ang numero ng mga sagot na totoo para sa iyo.

Pangkaraniwan kong ginagawa ito .....	Hindi	Minsan	Katamtaman	Madalas
1. Nagsisikap akong magtrabaho o gumawa ng ibang gawain para mapabaling ang aking pag-iisip sa ibang bagay.	1	2	3	4
2. Ibinubuhos ko ang aking pagsisikap sa ibang paraan tungkol sa kalagayan ko.	1	2	3	4
3. Sinasabi ko sa sarili ko na “Ito ay hindi totoo.”	1	2	3	4
4. Gumamit ng alak o ibang drugs/gamot para gumanda ang aking pakiramdam.	1	2	3	4
5. Kumukuha ako ng pangdamdaming tulong sa ibang tao.	1	2	3	4
6. Sumuko na akong magsumikap na harapin ang kalagayan ko.	1	2	3	4
7. Ako ay kumikilos para mapabuti ang kalagayan ko.	1	2	3	4
8. Ayaw kong paniwalaan na nangyari iyon.	1	2	3	4
9. Nagsasalita ako para makawala ang hindi magandang pakiramdam.	1	2	3	4
10. Sinusubukan kong humingi ng tulong at payo galing sa ibang tao.	1	2	3	4
11. Gumagamit ako ng alak at drugs para makatulong na makaraos ako.	1	2	3	4
12. Sinusubukan kong tingnan ito sa ibang paraan para higit na maging positibo.	1	2	3	4
13. Pinipintasan ko ang sarili ko.	1	2	3	4
14. Sinusubukan kong makahanap ng paraan kung ano ang gagawin.	1	2	3	4
15. Sinusubukan kong humanap ng kaginhawaan at pag-unawa ng iba.	1	2	3	4
16. Sumusuko akong sumubok kayanin.	1	2	3	4
17. Humahanap ako ng kung anong maganda sa nangyari.	1	2	3	4
18. Nagbibiro ako tungkol doon.	1	2	3	4



19. Gumagawa ako ng iba para paminsan minsan ko lang maalala, katulad ng panonood ng pelikula, telebisyon, nangangarap, nagbabasa, natutulog o namimili.	1	2	3	4
20. Tinatanggap ko ang katotohanan na nangyari yoon.	1	2	3	4
21. Ipinahihiwatig ko ang aking negatibong pakiramdam.	1	2	3	4
22. Sinusubukan kong makatagpo ng kaluwagan sa aking pananampalataya o paniniwala.	1	2	3	4
23. Sinusubukan kong kumuha ng tulong o payo sa ibang tao.	1	2	3	4
24. Matuto akong mamuhay na kasama iyong problema).	1	2	3	4
25. Pinagiiisipan kong mabuti kung anong pamamaraan ang gagawin.	1	2	3	4
26. Sinisisi ko ang aking sarili sa nangyari.	1	2	3	4
27. Ako ay nadarasal o nagninilay-nilay.	1	2	3	4
28. Pinagtatawanan ko ang katayuan.	1	2	3	4

#### BAHAGI 4. Kapaligiran

Bilugan ang bilang 0, 1, 2, 3 o 4 na nagpapahiwatig ng inyong pagayon sa tanong. Walang tama o maling sagot. Ang mga sagot ay ang mga sumusunod:

	Totoong totoo	Totoo	Hindi totoo	Hinding hindi
1. Iginagalang ako ng mga kaibigan ko	1	2	3	4
2. Nag-aalang alang ang pamilya ko sa akin	1	2	3	4
3. Hindi ako mahalaga sa iba.	1	2	3	4
4. Mataas ang pagpapahalaga sa akin ng pamilya ko	1	2	3	4
5. Ako ay isang kaibig-ibig na tao	1	2	3	4
6. Maasahan ko ang aking mga kaibigan	1	2	3	4
7. Talagang hinahangaan ako ang aking pamilya	1	2	3	4
8. Iginagalang ako ng ibang tao	1	2	3	4
9. Ako ay mahal na mahal ng aking pamilya	1	2	3	4
10. Ang mga kaibigan ko ay hindi nag-aalala sa akin	1	2	3	4
11. Umaasa sa akin ang miyembro ng pamilya ko	1	2	3	4
12. Mataas ang pagpapahalaga sa akin	1	2	3	4
13. Hindi ko maasahan ang pamilya ko na tumulong.	1	2	3	4
14. Ako ay hinahangaan ng tao	1	2	3	4
15. Sa pakiramdam ko, matatag ang pakikipag-kaibigan ko	1	2	3	4
16. Hinahanap ako ng mga kaibigan ko	1	2	3	4
17. Itinatangi ako ng ibang tao	1	2	3	4
18. Iginagalang ako ng mga kaibigan ko	1	2	3	4
19. Mahalaga ang bawat isa sa aking mga kaibigan at sa akin	1	2	3	4
20. Ang pakiramdam ko, kabilang ako	1	2	3	4
21. Kung ako ay mamatay bukas, kakaunti ang maghahanap sa akin	1	2	3	4
22. Pakirandam ko hindi ako malapit sa aking miyembro ng pamilya	1	2	3	4
23. Ang mga kaibigan ko at ako ay malaki ang pagtingin sa isat isa	1	2	3	4

38. Mayroon pa ba kayong gusting sabihin? \_\_\_\_\_

39. Kayo ba ay Taga-alaga (CARER) noon o ngayon ng inyong asawa, apo, magulang o ibang tao sa Australia?

1 Oo, Sagutin ang susunod na Bahagi 5.

2 Hindi, STOP here. Tapos na po.

*Salamat po na marami sa inyong pagsagot.*

### BAHAGI 5. PAG-AALAGA (CAREGIVING) SA PAMILYA

**40. Ang INAALAGAAN (Caree) ko ay aking:**

1 Asawa/kabiyak	2 Apo	3 Asawa at apo	4 Magulang	5 Ibang tao
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**41. Kasama mo ba sa bahay ang Inaalagaan mo?**

1 Oo

2 Hindi

**42. Kung Hindi, saan nakatira ang Inaalagaan mo?**

1 Kasama ng magulang	2 Nursing home	3 Hostel like Lions	4 Iba pang lugar
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**43. Inaalagaan mo parin ba siya/sila?**

1 Oo

2 Hindi

**44. Gaano katagal kang Taga-alaga?** \_\_\_\_\_ taon/buwan

**45. May ibang tao ka bang inaalagaan?**

1 Oo

2 Hindi

**46. Kung Oo, ano ang relasyon mo sa kanila?**

1 Asawa	2 Apo	3 Magulang	4 Anak	5 Kaibigan	6 Kamag-anak
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**47. Ano ang dahilan at ikaw ay naging TAGA-ALAGA (Carer) ?**

1 Para makapagtrabaho ang magulang	3 Para makapagpahinga ang mga magulang
2 May sakit ang inaalagaan	4 <i>Utang na loob</i> (eg, Binayaran nila ang visa ko.)

**48-49 . Para sa mga nagaalaga ng apo, ilan ang inyong inalagaan? \_\_\_\_\_**

**At ano ang edad sila?** \_\_\_\_\_

**50. Ano ang GANTIMPALA o POSITIBO bilang Taga-alaga?**

*(Tatlo lamang ang bilugan).*

1 Sundin ang Pilipino ugali na alagaan ang pamilya	6 Masaya na nakakatulong sa pamilya
2 Magturo ng Pilipino values, language & culture	7 Napalapit ang relasyon ng pamilya
3 Bilang halimbawa sa mga bata, para pagtanda namin ay alagaan din kami	8 Naunawaan ang serbisyong pangkalusugan at para sa mga tao
4 Nagbibigay ng pera ang anak	9 Magandang relasyon sa Australyanong manugang
5 Panatag ang kalooban na kamag-anak ang nag-aalaga sa mga bata	10 Pakiramdam ay kapakipakinabang at may kahulugan ang buhay

**51. Gumamit ka ba ng ibat-ibang serbisyo sa pag-aalaga?**

1 Oo

2 Hindi

**52. Kung Oo, aling mga SERBISYO ang iyong nilapitan o nilalapitan bilang TAGA-ALAGA? Sino ang trabahador, Pilipino o Australyano? (Bilugan kahit ilan).**

	Pilipino	Australyano
1 Centrelink		
2 Carer respite	1	2
3 Day care/drop-in centre	1	2
4 Childcare/playgroup	1	2
5 Transport support	1	2
6 Doctors and allied health	1	2
7 Telink program, Friendly visiting program	1	2
8 Church activities/spiritual director	1	2
9 Advocacy/Outreach	1	2

**53. Gaano kalaki ang naitulong sa iyo ng kanilang mga serbisyo? (Bilugan kahit ilan).**

	Hindi Nakatulong	Tama lang	Malaking Tulong
1 Centrelink	1	2	3
2 Carer respite	1	2	3
3 Day care/drop-in centre	1	2	3
4 Childcare/playgroup	1	2	3
5 Transport support	1	2	3
6 Doctors and allied health	1	2	3
7 Telelink program, Friendly visiting program	1	2	3
8 Church activities/spiritual director	1	2	3
9 Advocacy/Outreach	1	2	3

**54. Kung Hindi ka gumagamit ng serbisyo, bakit?**

1 Hindi ko sila alam	3 Hindi sila magaling
2 Hindi bagay sa aking kultura	4 Iba pang dahilan

**55. Ano ang mga SERBISYO na kailangan ng INAALAGAAN mo? (Bilugan kahit ilan).**

1 Child care	3 Residential care (eg, Nursing home)
2 Aged care services at home	4 Cluster Home (eg, Lions Seniors Homes)

**56. Nasiyahan/nasisiyahan ka ba sa mga serbisyong ito?**

	Hindi	Masaya	Masayang-masaya
1 Child care	1	2	3
2 Aged care services at home	1	2	3
3 Residential care (eg, Nursing home)	1	2	3
4 Cluster Home (eg, Lions Seniors Homes)	1	2	3

**57. Gaano kahalaga ang mga serbisyong ito sa iyo?**

	Hindi Mahalaga	Mahalaga	Napaka- halaga
1 Taxi concession for carers when not with Caree	1	2	3
2 Intensive outreach by Filipino professionals	1	2	3
3 Babies group for grandparents	1	2	3
4 Carer support group	1	2	3
5 In home respite	1	2	3
6 Out of home respite (Hostel, Nursing home, other aged care facilities)	1	2	3
7 Planned respite	1	2	3
8 Emergency respite	1	2	3
9 Other (pls specify):	1	2	3

**58. Ikaw ba ay nagaalaga ng isang taong may Dementia or complex care needs?**

1 Oo                      2 Hindi

**59. Mayroon ka bang ibang gustong sabihin?**


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**60. Payag ba kayong muling tanungin (interview)?**

1 Oo

2 Hindi

**61. Kung Oo, isulat ang inyong pangalan at telepono:**

Name: \_\_\_\_\_ Ph No.: \_\_\_\_\_

TAPOS NA PO. END of Questionnaire.

Maraming salamat po sa inyong pagsali at pagtaguyod.

## **APPENDIX K: List of Interview Questions (Filipino Brides in Focus) – Stage 2**

### **BRIDES AND GRANDMOTHERS: CHALLENGES FOR OLDER FILIPINOS IN AUSTRALIA**

#### **STAGE 2 GUIDELINE QUESTIONS:**

##### The meeting

1. How and where did you meet your husband?
2. What made you decide to marry a foreigner/Australian?
3. What made your husband decide to marry a Filipina?
4. How long did you know each other?
5. How did you correspond?
6. Have you been to Australia before meeting your husband?
7. Did your husband visit you in the Philippines before you got engaged or married?
8. Has he been married before? To a Filipina? An Australian? Another nationality?
9. What is the age difference between you and your husband?
10. Have you been married before marrying an Australian?

##### Ideas of marriage

11. What are your ideas about marriage?
12. What makes good marriage?
13. How did your family react to your relationship with a foreigner?
14. How did they react to your marriage plans?
15. How was the wedding? Where was it? Who was there from your family or friends?

##### In Australia

16. How did you picture your life in Australia?
17. Did you have any reservations about coming here? What were they?
18. What did you think of Australia?
19. How was your relationship at the start?
20. Were there issues or points of tension/disagreement that came out? What were they?
21. How did you feel with them? (sources of support)

22. Did you tell your family in the Philippines about your problems?
23. If you did, what was their reaction?
24. If you did not tell them, why not or what stopped you?
25. Do you have children? Did you want to have children?
26. What would be different if you have children?
27. How did you meet other Filipinos in Australia?
28. How did they react to your marriage?
29. How is your relationship with your husband now? Why has it become like this?
30. How is your relationship with his family?
31. Do you have recommendations for other women, community groups, and government agencies?
32. Do you work? Do you want to work?
33. What type of work do you do?
34. What types of work are you qualified to do?
35. What happens to your income?
36. Did you work in the Philippines? What type of work?
37. What happened to your income over there?
38. How is your general health?
39. How is your husband's general health?
40. Socio-economic background including of husband – education, occupation, age, marital history)
41. Other siblings abroad? Their education and occupations?
42. Send money to the Philippines?
43. Plans to sponsor a family here